THE SOURCE

ENHANCING PROVIDER PERFORMANCE & CLINICAL INTEGRATION

Q3 2020 | V 15 NO. 3 | HEALTHTRUST

CLINICAL WARRIORS

Front-line workers prove to be everyday heroes in the battle against COVID-19

STRATEGIZING DURING A PANDEMIC

Healthcare facilities across the nation react to the new normal

A WEB OF WEAK SPOTS

Cyberattacks during COVID-19 emphasize a need for better security

COVID-19 RESOURCES

For information about HealthTrust's resources and support, see page 19.

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1. Young DA, et al. Comparison of in vivo remodeling of urinary bladder matrix and acellular dermal matrix in an ovine model. Regenerative Medicine. 2018; doi: 10.2217/rme-2018-0091.
2. Sasse, et al. Long-term clinical, radiological, and histological follow-up after complex ventral incisional hernia repair using urinary bladder matrix graft reinforcement: a retrospective cohortstudy. Hernia. 2018;22(6): 899-907.

* ACell products are not regulated as biologics by the FDA. They are regulated as medical devices.

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FEATURES

EDITORIAL CONTRIBUTIONS:
Clinicians and staff within HealthTrust member facilities are invited to share their expertise as part of upcoming stories. Readers are also invited to suggest other experts for interviews or article ideas for publication consideration. Preference is given to topics that represent:

* Clinical or supply chain initiatives that exemplify industry best practices
* Physician Advisor expertise
* Innovation, new technology, insights from data and analytics
* Positive impacts to cost, quality, outcomes and/or the patient experience

Contact Faye Porter at **faye.porter@healthtrustpg.com** with suggestions. (Note: HealthTrust reserves the right to edit all articles and information accepted for publication.)

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HealthTrust (Healthtrust Purchasing Group, L.P.) is committed to strengthening provider performance and clinical excellence through an aligned membership model and the delivery of total spend management advisory solutions that leverage our operator experience, scale and innovation. Headquartered in Nashville, Tennessee, HealthTrust (**healthtrustpg.com**) serves over 1,600 hospitals and health systems, and more than 40,000 other member locations including ambulatory surgery centers, physician practices, long-term care and alternate care sites. Follow us on Twitter **@healthtrustpg**.

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HLT-013

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CEO perspective

Advancing through the aftermath

Healthcare organizations throughout the country are currently managing the delicate balance between increasing elective procedures and services while maintaining bed capacity in the event of a COVID-19 resurgence. As of this writing in early July, there was a surge across Florida, Texas and Arizona.

Gating criteria proposed by the Trump administration discouraged the opening of elective surgeries without a 14-day decrease in both the number of COVID-19 cases and patients with positive test results. As states reopen, many will need to take action to make the Centers for Medicaid and Medicare Services' (CMS) COVID-19 Telehealth Program changes permanent, once emergency orders are lifted.

Prior to the pandemic, many healthcare organizations had been using telemedicine in small pockets for specific patient populations, and insurance companies were reimbursing for just a limited number of services. However, during COVID-19, telemedicine reimbursement was widely expanded by CMS as part of the $2 trillion CARES (Coronavirus Aid, Relief and Economic Security) Act. CMS also temporarily waived Health Insurance Portability and Accountability Act (HIPAA) violations against providers who serve patients in good faith through communications technologies. Could telemedicine be here to stay? HealthTrust Physician Advisors and nursing leaders share their experiences on page 34.

Since early March, HealthTrust personnel have vetted more than 2,000 leads to secure quality personal protective equipment (PPE), ventilators, lab tests and other products critical to the thousands of caregivers battling the pandemic on the frontlines. As stay-at-home orders were put into place, the majority of HealthTrust employees worked remotely and were temporarily restructured into one or two of 13 workstreams aimed at supporting various aspects of the COVID fight. Learn more about those workstreams in the Leading Practices article on page 18.

As COVID-19 began to pervade the U.S., there were countless businesses, large and small, that were instrumental in assisting HealthTrust and hospitals throughout the country in obtaining critical supplies. We are honored to share a number of those examples in Agents of Change on page 69.

Clinicians and staff in our members' facilities have made incredible sacrifices in the fight against COVID-19, and we recognize their efforts publicly in a new HealthTrust Clinical Warriors section of our website and on social media outlets. This edition also highlights a few of their stories in the Clinical Warriors Spotlight on page 72. **HT**

If you know of a warrior clinician or a team on the frontlines with a story to share, please tell us about it at surveygizmo.com/s3/5542956/HealthTrust-Clinical-Warrior-Submissions

Ed Jones
President/CEO, HealthTrust
Publisher, *The Source* magazine

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CMO perspective

Aligning around a post-COVID prognosis

At the time of this writing, the majority of HealthTrust member facilities are actively resuming elective procedures and routine care, while others anticipate a potential second wave of COVID-19 cases. The toll of the pandemic remains to be seen, as does the speed at which an efficacious vaccine enters the market. Hardest hit areas of the country will hold their breath in the months ahead as prognosticators suggest additional COVID waves may emerge in the fall and winter.

HealthTrust continues its support of member hospitals by developing, vetting and curating clinical content to help you strategize and plan for the weeks and months ahead. You will find more than 100 COVID-19-related documents on our Education & Clinical Resources website: **https://education.healthtrustpg.com/clinical-resources/#covid-19**

To highlight the pandemic response of some of our members, Physician Advisors and those recognized as HealthTrust Clinical Warriors, we initiated a podcast series—Candid Conversations (**https://healthtrust.podbean.com**). I recently had the opportunity to talk with:

- HealthTrust Physician Advisor **S. Shaefer Spires**, M.D., an infectious disease specialist with Duke Health. In episode 8, Dr. Spires discusses the return to elective surgeries, COVID-19 testing, the effectiveness of antibody testing and medications for treating the virus.
- **Sue Shugart**, CEO of Kershaw Health in Camden, South Carolina. Kershaw Health was the first LifePoint Health facility to identify and treat a COVID-19 patient. In episode 9, Sue talks about the impact of the pandemic on patients and staff, the necessary response to the disease, management of personal protective equipment (PPE) and how the facility is prepared for a potential second wave.

Read about more of our Candid Conversations in our piece on Clinical Warriors on page 72. We anticipate expanding the conversations beyond COVID-19 once the pandemic transitions to the rearview mirror.

THE SOURCE MAGAZINE

As Executive Publisher and Editor-at-large of the *The Source*, I appreciate the feedback many of you provided through a reader survey initiated after the publication of the Q4 2019 edition. I'm pleased to share that the new appearance, the content and the overall opinion of the publication have received positive responses.

See an overview of results on page 38. Please consider participating in our current reader survey at the link below to help us to continue making improvements. **HT**

John Young, M.D., MBA, CPE, FACHE
Chief Medical Officer, HealthTrust
Executive Publisher & Editor-at-large, *The Source* magazine

A new reader survey is being conducted right now. Please visit TheSource2020.QuestionPro.com and be entered into a drawing for a chance to win one of five $75 gift cards. In the meantime, feel free to share your feedback or stories at any time by emailing thesource@healthtrustpg.com

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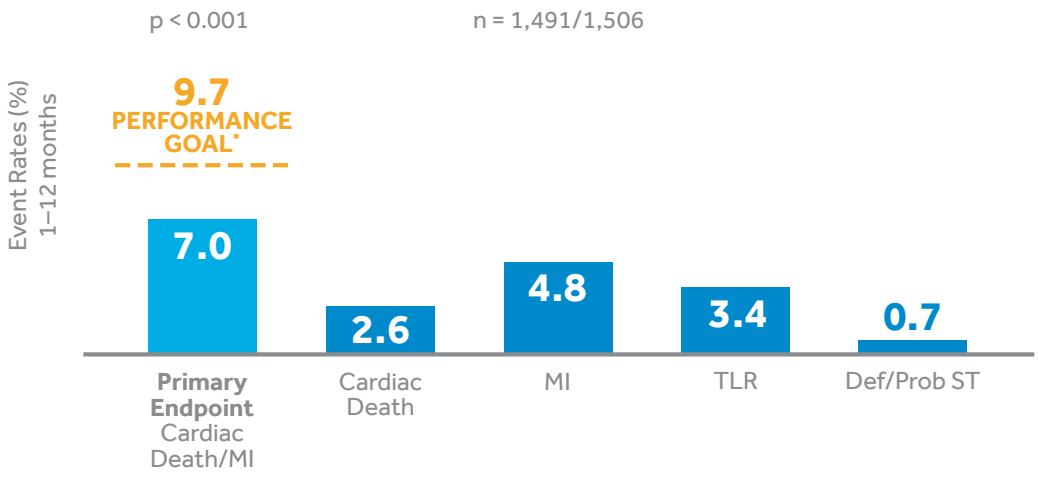
ONYX ONE CLEAR STUDY ANALYSIS[1]



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HealthTrust members recognized for environmental excellence

Practice Greenhealth's Environmental Excellence Awards annually honor outstanding sustainability achievements in the healthcare sector. Congratulations to the HealthTrust member health systems and facilities below that were announced in May.

ATLANTIC HEALTH SYSTEM

System for Change Award

Highest honor: Top 25 Environmental Excellence

2 Circle of Excellence Awards – Greening the Operating Room, Food

- Atlantic Health System – Overlook Medical Center

Partner for Change

- Atlantic Health System – Chilton Medical Center
- Atlantic Health System – Hackettstown Medical Center
- Atlantic Health System – Morristown Medical Center
- Atlantic Health System – Newton Medical Center

BETH ISRAEL LAHEY HEALTH

Circle of Excellence – Climate
Greenhealth Emerald
Greening the Operating Room

- Beth Israel Deaconess Medical Center

4 HealthTrust members' facilities were named to the Top 25 list of U.S. hospitals recognized for environmental excellence:

- **Atlantic Health System – Overlook Medical Center**
- **Boston Medical Center**
- **Hackensack Meridian Hackensack University Medical Center**
- **Hackensack Meridian Jersey Shore University Medical Center**

Continued on page 76

Illuminating the barriers to biosimilars

HealthTrust survey pinpoints the obstacles to adoption of less-expensive drug alternatives

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If two products are equally effective at treating a condition, choosing the less-costly option might seem obvious. But that's not what's happening in the fraught competition between pricey biologics and their less-expensive alternatives, known as biosimilars.

A biosimilar is a biological product with no clinically meaningful differences from a reference biologic product approved by the Food and Drug Administration (FDA)—such as monoclonal antibodies, vaccines or therapeutic proteins. While biosimilars comprise the same safety, purity and potency, payer preferences have limited broad adoption of them in the U.S. market.

Only about 2% of Americans use biologic drugs for conditions ranging from rheumatoid arthritis to low blood cell counts seen in treatment of various cancers, yet these therapies represent 40% of the nation's total spend on all prescription drugs. By comparison, a biosimilar typically enters the market at a discount ranging from around 15% to 30% off the price of its reference biologic.

"Biosimilars introduce a massive savings opportunity, not only for the consumer but the healthcare system as well," explains **Kyle Herndon**, PharmD, MBA, BCPS, PGY-2 Corporate Pharmacy Leadership Resident in HealthTrust Pharmacy Services. But slow adoption is getting in the way of realizing these savings, and the reasons are complicated. "Why wouldn't people want to adopt the means to save the healthcare system money? There is a lot of mystery as to why some biosimilars can't come to the market in a more timely manner."

DELAYED LAUNCHES

To delve into these dynamics, Herndon recently focused on biosimilar payer preferences and perspectives surrounding adoption as his PGY-2 research project. He accomplished this by surveying members across HealthTrust, including health systems and physician practices, in addition to pharmaceutical manufacturers.

Herndon's report details the launch of various biosimilars over the years, contrasting the approval date with the lag time before the biosimilars were actually available on the market. As of April 2020, 17 of the 26 FDA-approved biosimilars (65%) had come onto the U.S. market—eight of which had done so within the prior six months.

The average time between FDA approval of a biosimilar and its launch date is around 13 months, with many taking much longer. (Some of these molecules have been FDA approved since 2016 and will not be coming to market until 2023 or later.) Herndon found this to be a stark contrast to the one-month separation time that's typical for a biologic.

SLOW ADOPTION

Even after launch, biosimilars face an array of adoption challenges, including:

- Providers' concerns surrounding safety and efficacy
- Missing indications
- Lack of interchangeability
- Whether the product is intended for chronic versus episodic therapy
- Preferred payer status

The No. 1 hurdle in adopting biosimilars? Rebates. Manufacturers of biologic drugs often offer rebates to payers that list their drug as the preferred therapy rather than a competing biosimilar. According to Herndon's survey results, these rebates are the biggest barrier.

Nine of 15 top payers, for example, listed Remicade (infliximab) as the preferred drug for rheumatoid arthritis, rather than favoring one of the less-expensive biosimilars, Inflectra or Renflexis. Biosimilars, however, tend to gain favor with payers the longer they're on the market, based on Herndon's results.

The survey also found that biosimilars for acute care products, such as Zarxio (filgrastim), have shown the quickest adoption, while outpatient infusion centers—along with outpatient specialty and retail classes of biosimilars—have seen the slowest adoption.

LOOKING AHEAD

Federal action supporting biosimilar use has included two pieces of legislation from 2010 and 2018 meant to facilitate biosimilar competition and adoption.

"The federal government is all about spending less, if it can," Herndon says. "So it can get the best deal on a product, the government has negotiations with pharmaceutical companies, just like a third-party payer would. At the end of the day, it's all about cost."

Overcoming adoption obstacles could be achieved in a variety of ways, Herndon explains. For one, biosimilar manufacturers could make their products available at an even greater discount while still being profitable. Another path toward overcoming obstacles rests with the FDA, Herndon adds. If the FDA offers "interchangeability status" to more biosimilars, this may increase use by allowing the substitution of biosimilars for reference biologics. Currently, the FDA requires additional study data to grant interchangeability status. "I think it starts with calling out what the actual savings would be, even if you compared the strict wholesale cost of the reference drug to the biosimilar," he says.

As for his research, Herndon adds: "We hope to gain recognition among other healthcare professionals and the government through publication in a nationally recognized pharmacy journal. By using this platform to reach a broad audience, we hope to effect change and increase the use of biosimilars to reduce spending across the U.S. healthcare system." **HT**

TO LEARN MORE about biosimilars, contact Kyle Herndon at kyle.herndon@healthtrustpg.com

Mind the gap

Bridging gaps in access to care can improve patient outcomes

Access to healthcare is as important as the quality of the care itself. Obstacles such as language barriers and lack of transportation options can have a significant impact on patients—potentially leading to missed appointments, longer hospital stays, increased readmission rates and a higher likelihood of adverse medical outcomes.

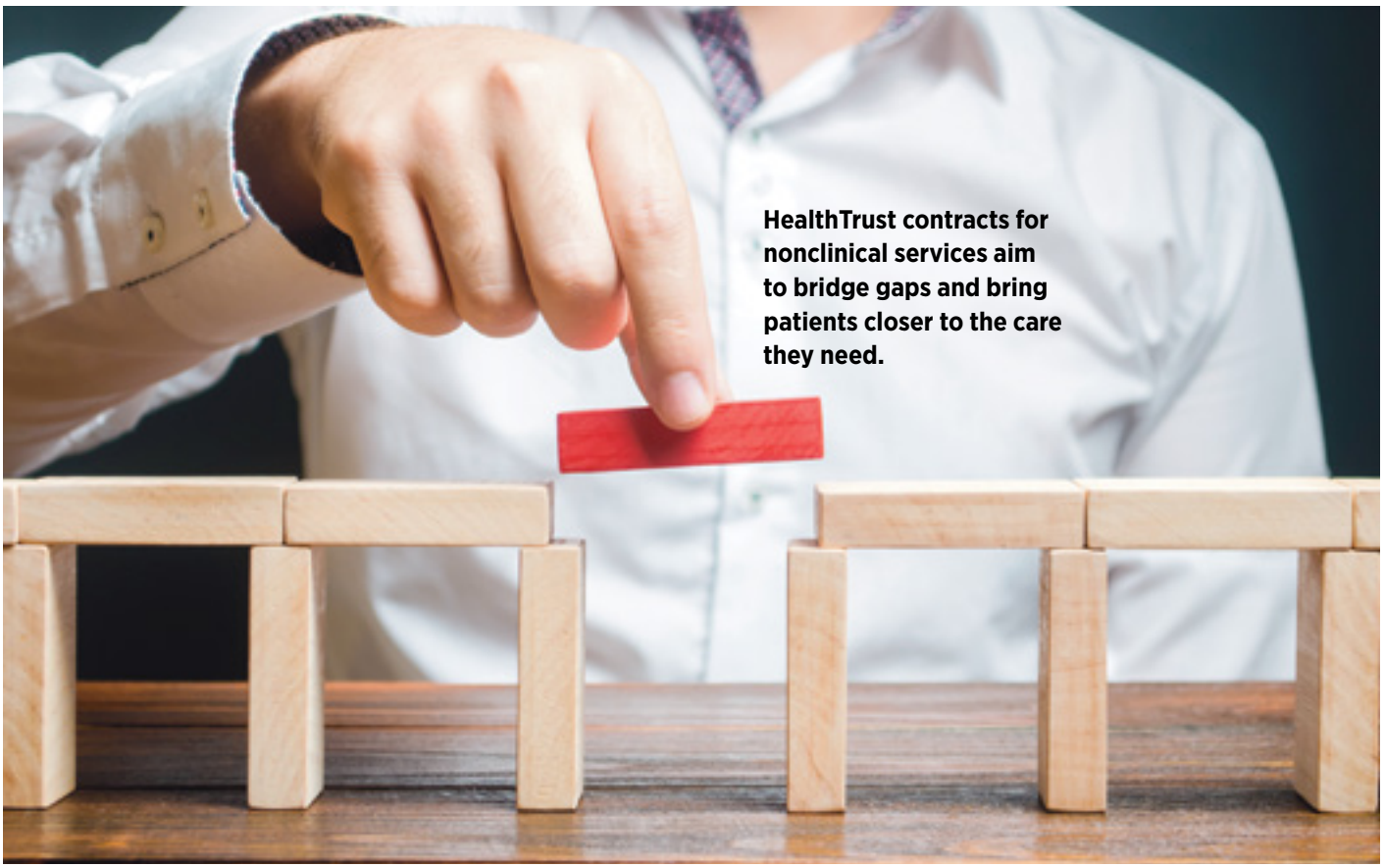
Contracts for nonclinical services in the HealthTrust portfolio aim to bridge these gaps and bring patients closer to the care they need.

OPEN TO INTERPRETATION

One in 12 Americans does not speak English very well, according to the U.S. Census. This isn't surprising, as more than 350 languages are spoken in this country, says **Yolanda Robles**, CEO of CulturaLink, a medical interpretation supplier (HealthTrust contract #6225). This number is continually growing, she explains, with more people whose primary language is not English coming into the country each day—in particular from Africa and rural areas in Mexico and Guatemala.

"The face of America is changing, and it's changing the face of healthcare," Robles says. Because of this ongoing transformation, remote interpretation via phone and video has become an integral part of most healthcare systems' services.

Non-English-proficient patients who don't have access to interpretation services could face a variety of medical risks, explains **Robyn Suminski**, Vice President of Account Operations at CyraCom (HealthTrust contract #2905). They could remain at the



HealthTrust contracts for nonclinical services aim to bridge gaps and bring patients closer to the care they need.

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hospital longer than needed, be misdiagnosed, be subject to medical errors, struggle to understand their condition or be readmitted to the hospital. "Everyone has a right to receive the best medical care and outcomes, regardless of their background or the language they speak. The use of medical interpreters reduces these disparities and improves clinical outcomes," says Suminski.

Angie Mitchell, RN, AVP, Clinical Services at HealthTrust, says the practice in years past was to allow family members and friends to translate or interpret for patients, but it fell short. "Their ability to effectively and accurately translate or interpret medical information was not there," Mitchell adds. For two decades or more, The Joint Commission has had standards in place requiring the provision for interpretation and translation services. As a result, many healthcare systems engage professional interpreters to fill this role. Medical interpreters undergo extensive training (often upward of 100 hours) in medical terminology, making them uniquely qualified to interpret complicated clinical information. "This is critical in order to ensure there is an effective care plan that the patient understands and can be an active participant in," explains Mitchell.

While most healthcare institutions offer robust interpretation services, there are still gaps. One 2016 study found that nearly one-third of U.S. hospitals fail to offer interpreters to patients who speak limited English—despite federal mandates, per the Civil Rights Act of 1964.

Although this statistic is worrisome, the medical interpretation industry is making strides in the right direction. **Scott F. Cooper**, Esquire, Managing Director at Language Services Associates (HealthTrust contract #2926), explains that the industry as a whole has grown in recent years. And access to interpretation services in rural areas has improved drastically due to technological advances. "If you live in a rural area, your access to an interpreter might have been significantly more limited a few years ago, before it became easier to patch somebody in through a cellphone or video conference call," he says. "This is one of the more encouraging things

happening—that in the future, there will be greater access to more languages irrespective of where you live."

THE ROAD TO BETTER CARE

Limited access to nonemergency medical transportation (NEMT) can affect a patient's entire continuum of care, leading to missed appointments and, ultimately, worse outcomes. The American Hospital Association (AHA) found that 3.6 million Americans miss medical appointments each year due to a lack of transportation services.

While this barrier exists throughout the country, it's especially persistent in rural areas, low-income neighborhoods and communities with high elderly, disabled and chronically ill populations, says **Sven Johnson**, Senior Vice President of Innovative Operations at Global Medical Response (GMR) (HealthTrust contract #7340). A study published in 2013 found that 1 in 4 low-income patients missed or rescheduled a medical appointment due to lack of NEMT services, Johnson says. And in rural communities, where as many as 25% of hospitals risk closure, the outlook is bleak. "Not only is there a challenge today, but that challenge is becoming more pronounced over time as medical resources in those communities become more and more limited," Johnson adds.

The transportation gap has a deleterious ripple effect. Research from McKinsey & Company conducted in 2019 found that people with unmet transportation needs were 2.6 times more likely to report multiple emergency room visits and 2.2 times more likely to be admitted as an inpatient within a year. "That's a significant increase in health system costs," Johnson notes. "It impacts readmission rates and other key measures for facilities. Plus, on an individual level, it results in more adverse healthcare outcomes."

Companies like GMR work to bridge this gap. Access to Care, the transportation division of GMR, primarily works with Medicaid, Medicare, health insurance plans and governmental institutions to provide NEMT services to underserved populations, says **Matthew McCormick**, GMR's Vice President of Commercial Managed Transportation.

Fortunately, this sector has seen growth in recent years. McCormick notes some pilot programs have popped up in some areas of the country where, for instance, an employed but low-income pregnant woman can get free transportation to prenatal visits.

However, if not designed and operated properly, patient transportation services might be considered an improper inducement to gain patients or enticement to provide care. According to **Kim Allen**, Senior Director of Contracts on HealthTrust's Commercial Services team, laws and regulations, including the federal Anti-Kickback Statute, as well as varying state and local requirements, mean that every healthcare organization needs its own policies regarding patient transportation. "Any facility wanting to put a patient rideshare program in place should have the following stakeholders involved early on in the discussion process: Care Management, Procurement, Legal and Compliance. Personnel from these teams can develop your best use cases and map out the pros and cons of each solution, while ensuring compliance with the law," says Allen.

In 2017, the Department of Health and Human Services Office of Inspector General (HHS OIG) implemented a Patient Transportation Safe Harbor to the federal Anti-Kickback Statute establishing requirements that, if followed, affords protection to healthcare providers who wish to offer free or discounted local transportation to federal health program beneficiaries.

The safe harbor paved the way for healthcare providers to evaluate opportunities with rideshare companies to schedule rides for their established patients who needed help getting to and from medical appointments. HealthTrust has a contract with Lyft (#27671) to offer its members patient (and staff) rideshare programs. On behalf of the membership, HealthTrust has also executed a Business Associate Agreement (BAA) with Lyft to ensure Health Insurance Portability and Accountability Act (HIPAA)-compliant handling of any protected health information (PHI), as well as additional security measures.

ACCELERATING CHANGE

Despite the immense challenges our country has faced during the COVID-19 pandemic, the crisis has forced healthcare institutions across the country to implement innovative solutions for both clinical and nonclinical barriers to care. Telemedicine, for example, will likely be a fundamental part of our healthcare system following the pandemic, Robles says. (See page 34 for more on telemedicine in the time of COVID-19.)

"Overall, COVID-19 has helped us think outside of the box," Mitchell notes. "Some of the efficiencies and ideas that have come about because of the pandemic might have some longevity in healthcare."

Cooper agrees. "COVID-19 seems to be changing things much faster than years of lobbying to change some of these rules could," he adds. **HT**

VIEW DETAILS of HealthTrust's agreement with Lyft in the contract package. For additional information on creating a rideshare program, contact Kim Allen at kim.allen@healthtrustpg.com. For more details on GMR or language service suppliers, contact Eric Clapp, Contract Manager, Strategic Sourcing, at eric.clapp@healthtrustpg.com

LANGUAGE SERVICE SUPPLIERS

The following medical interpretation suppliers are contracted with HealthTrust:
CulturaLink: contract #6225
CyraCom: contract #2905
Language Services Associates: contract #2926
Stratus Video (declined to comment): contract #16406

SPEAKING YOUR LANGUAGE

Medical interpretation suppliers contracted with HealthTrust offer hundreds of languages and dialects on an on-demand basis. According to CyraCom, these are the top 10 most-requested languages:

1. Spanish
2. Mandarin
3. Vietnamese
4. Arabic
5. Russian
6. Haitian Creole
7. Korean
8. Cantonese
9. Nepali
10. Brazilian Portuguese

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Motherhood matters

New Joint Commission guidelines aim to reduce maternal mortality & morbidity

Of every 100,000 births in the U.S., there are 17.4 maternal deaths—ranking the U.S. 65th among industrialized nations, according to the Centers for Disease Control and Prevention (CDC). To combat this problem, The Joint Commission has taken aim at two key factors influencing maternal mortality and morbidity—hemorrhage and severe hypertension/preeclampsia—in its latest guideline changes.

Taking effect in January 2021 (delayed from an original date of July 2020), the requirements apply 13 new elements of performance to Joint Commission-accredited hospitals. According to The Joint Commission, a comprehensive literature review "revealed that prevention, early recognition and timely treatment" for those two maternal conditions could produce the greatest impact in states working to reduce maternal complications.

"You'd think from all the technology and resources we have, the United States should have the lowest maternal mortality rate," says HealthTrust Physician Advisor **Frank Kolucki**, M.D., FACOG, Chairman of the Department of Obstetrics at Moses Taylor Hospital in Scranton, Pennsylvania, and the Community Health Systems Obstetrics and Gynecology Advisor.

"One of the barriers has been a lack of evidence-based protocols for how to treat women who have significant complications," he says. "The Joint Commission is promoting standardization and a heightened preparedness on behalf of hospitals."

KEY MEASURES

The Joint Commission's new guidelines are part of an ongoing effort to address and improve various aspects of perinatal care, Dr. Kolucki notes. Scenarios targeted in recent years include elective deliveries, primary cesarean sections, and neonatal mortality and morbidity.

As the first in the country to be accredited as a Perinatal Center of Excellence in 2015, Moses Taylor Hospital has been tapped by The Joint Commission to provide its protocols surrounding maternal care for the Commission's library. There, other institutions aspiring to achieve this certification can access this information.

Dr. Kolucki points out that maternal hemorrhage and severe hypertension/preeclampsia are "two high-focus areas" when the goal is cutting complications and deaths in the perinatal setting. "These are two disease processes that can really move the needle when you're hoping to decrease maternal morbidity and mortality," he explains. "Studies have shown that up to 70% of deaths associated with hemorrhage are preventable, as are 50% of those associated with hypertensive emergencies."

Several key measures outlined in The Joint Commission's new guidelines include:

- Developing written evidence-based procedures for managing patients who are experiencing maternal hemorrhage or high blood pressure
- Creating standardized, dedicated hemorrhage supply kits
- Providing role-specific education to all staff members and providers regarding the hospital's procedures during these patient scenarios
- Conducting drills at least once a year to determine opportunities for process improvements
- Providing education to patients and families about these conditions

Moving these standards forward will require a mindset change. "It's not just about having a simple toolkit," adds Dr. Kolucki. "This is a culture shift that will provide great dividends."

HealthTrust's Nursing Advisory Board and Perinatal Specialty Committee both played an integral role in

Continued on page 16

For the tireless, the selfless, the brave

You mean the world

Whether you are working on the frontlines or are the last line of defense in the fight against COVID-19, you are making a world of difference for so many. **Thank you.**

bd.com/COVID-19

HealthTrust Contract #7110

BD

Continued from page 14

providing feedback and reviewing equipment to meet the new Joint Commission guidelines, says **Tara Coleman**, MBA, BSN, RN, Director, Nursing Services, Clinical Operations. Coleman adds that for the HealthTrust category Blood/Fluid Warming Equipment and Supplies, the Advisory Boards reviewed equipment for rapid infusion of blood products and IV solutions to help prevent hypothermia, which often occur during maternal hemorrhage.

CREATING A CULTURE OF SAFETY

Dr. Kolucki explains that most highly reliable hospitals will have at least some of these performance elements already in place as part of their perinatal care. But for some, the new requirements will serve as a checklist—and perhaps an incentive—to fuel efforts to become a Perinatal Center of Excellence. "I support The Joint Commission's efforts in requiring these standard processes for maternal care," he says.

Healthcare facilities will face certain obstacles in implementing The Joint Commission requirements, Dr. Kolucki says. First and foremost is making sure they practice in a culture of safety and collaboration.

"Obstetrics, perhaps more than any other specialty, is a team sport," notes Dr. Kolucki. "It's not just the birth attendant, physician or midwife taking care of the patient—it's everyone who's engaged in her care. Therefore, it's imperative to foster a team-based culture of safety."

For information on how COVID-19 is affecting pregnancy, visit the full version of this article online at healthtrustpg.com/MaternalMortality HT

Dr. Kolucki will offer two new programs on maternal morbidity and hypertension. Visit education.healthtrustpg.com to sign up or listen to a recording. For more information on contracted products in related categories, contact Tara Coleman at tara.coleman@healthtrustpg.com

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HealthTrust Contract #46129

BATTLE READY

HealthTrust supports members with critical supplies, clinical & supply chain COVID-19 resources

AS THE PANDEMIC BEGAN TO MAKE ITS APPEARANCE IN U.S. HOSPITALS, HealthTrust launched its response in supporting member facilities across the country in the fight against COVID-19.

"The battle was one of epic proportion, made even more difficult by an invisible enemy," says HealthTrust CEO **Ed Jones**. "Our GPO is the critical supply line in empowering and protecting our members' caregivers with the gear needed to endure and win the fight."

A major challenge, however, was the unprecedented global demand for those products. It was outstripping supply by a significant margin. Jones adds, "Never have we had a situation where the entire world was in a race to secure these critical products, and the raw materials needed to create them, at the same time."

Since early March, HealthTrust personnel have diligently vetted more than 2,000 leads to secure quality personal protective equipment (PPE), ventilators, lab tests and other products critical to the thousands of caregivers battling COVID on the frontlines. As stay-at-home orders were put in place, the majority of HealthTrust colleagues worked remotely and were temporarily restructured into one or two of 13 workstreams aimed at supporting various aspects of the COVID fight:

- **The Administration** workstream chased more than 2,000 leads and extended many existing contracts to avoid potential supply disruptions. Every potential supplier was vetted for product viability and quality standards. As COO **Michael Berryhill** advised the team, "It is just as important to keep bad products out of the system as it is to find good products."

  Products were added to existing agreements, such as COVID-19 serology antibody IGG tests, SARS-CoV-2 testing products, Level 1 ear loop masks and positioning aids. New product agreements were signed for UV light disinfection systems, emergency surge patient beds and respiratory bronchial hygiene, among others. The Cross Reference team helped maintain the categorization and cross accuracy of new products that were introduced.
- **The Alternative Approaches** work group provided clinical support by evaluating the feasibility of innovative products, concepts and processes, and making available on the HealthTrust public education site clinical practice documents and summaries of federal guidance on alternative practices such as PPE decontamination.

TRUSTED RESOURCES

In addition to developing more than 120 resources, HealthTrust served a critical role in vetting and curating a lot of the publicly available content about COVID-19 to provide members with easy access to quality information from trusted sources.

Member Resources Center | Found on the secure Member Portal, the site features exclusive, members-only clinical, pharmacy and supply chain COVID-19 content related to supplies and suppliers, drugs, treatment evidence, and caring for patients, as well as condensed versions of guidelines from the Food and Drug Administration (FDA) and other national organizations. Pandemic-related offerings from suppliers in the Purchased Services, Facility Services & Equipment and the Nonclinical Product space are also included.

Clinical Resources | Clinical experts created and continue to update >120 important tools and resources on clinical COVID-19 topics such as lab & diagnostic testing, disinfection, PPE, respiratory care, clinical practice, resuming care and more: **https://education.healthtrustpg.com/clinical-resources/#covid-19**

Public & Member Resources | A pandemic-inspired homepage on HealthTrust's public website features links to resources from the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and more, as well as an interactive dashboard developed by HealthTrust's data scientist: **healthtrustpg.com**

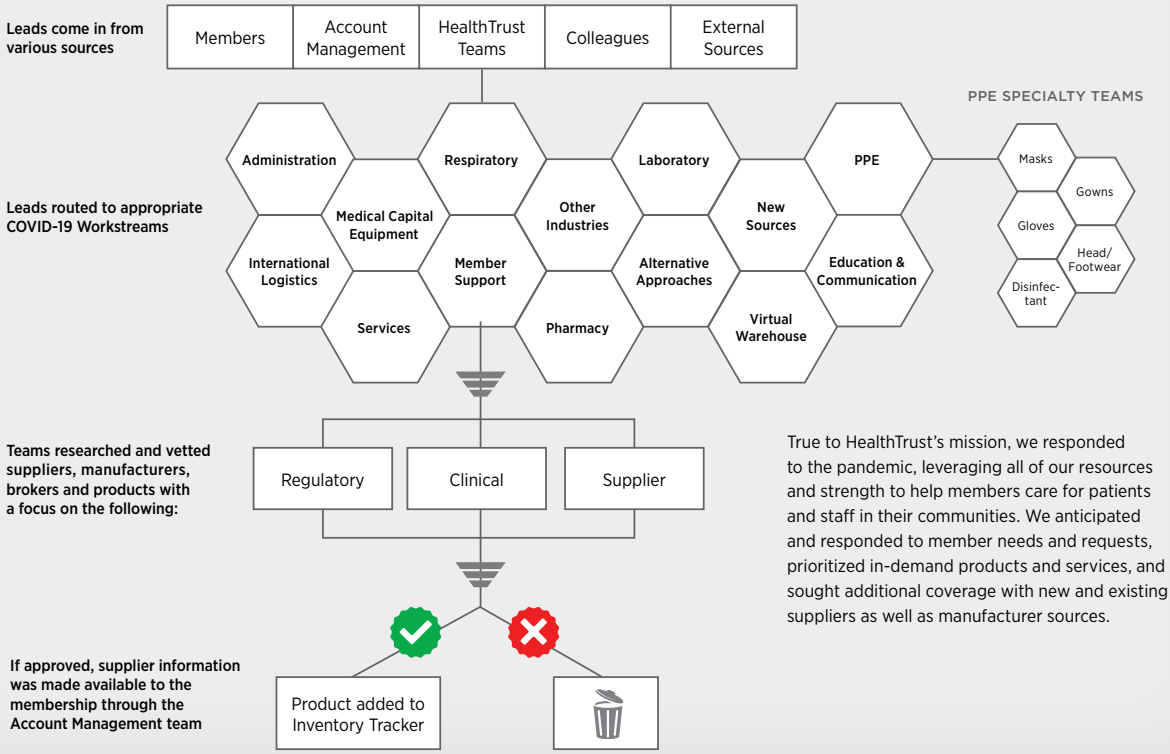
Clinical Warriors | Clinicians and staff in HealthTrust members' facilities made incredible sacrifices in the fight against COVID-19. We recognize their efforts publicly on social media and in a new section of our website: **https://education.healthtrustpg.com/clinical-warriors**. Share stories about your Clinical Warriors by clicking on the form within that site. (See related story on page 72.)

Candid Conservations | This new podcast series features interviews with HealthTrust Clinical Warriors, Physician Advisors and others members, sharing their experiences related to the pandemic, lessons learned and best practices. Access the podcasts: **https://healthtrust.podbean.com**

- **The Commercial Services** workstream helped to arrange airfreight and other modes of shipments through HealthTrust transportation partners; scheduled same-day logistics for COVID lab tests; helped deliver and install bulk oxygen tanks; and, it orchestrated an agreement to sell convalescent plasma. The Purchased Services team contracted for medical waste disposal, disinfection services, generators, laundry services and refrigerated trucks.
- **Education & Communications** team members provided their writing and communications expertise in support of the deliverables of various workstreams and in creating COVID-19 resources for HealthTrust members.
- **The Laboratory** work group sourced consumables for specimen collection, including swabs and tubes with viral transport media. The team also sought FDA Emergency Use Authorizations for various types of non-traditional media.
- **The Medical Capital Equipment** workstream sourced IV pumps, beds and stretchers (for purchase and rental), thermometry devices and UV disinfection systems, locating suppliers with short turnaround times.
- **The Member Support** work group kept in close contact with members and their assigned account management resources throughout the crisis to assess their situations and anticipate supply needs. Through collaboration with other workstreams, communications kept member executives and supply chain and clinical leaders informed of HealthTrust's COVID support initiatives. In addition to clinical and PPE conservation guidance, a PPE toolkit and calculator have proved helpful to members in managing

Workstreams

HealthTrust teams were realigned to designated workstreams to respond to the pandemic, dedicated to meeting the needs of our members.



True to HealthTrust's mission, we responded to the pandemic, leveraging all of our resources and strength to help members care for patients and staff in their communities. We anticipated and responded to member needs and requests, prioritized in-demand products and services, and sought additional coverage with new and existing suppliers as well as manufacturer sources.

scarce supplies and in benchmarking utilization rates.

- **The New Manufacturing/New Sources** team worked with Ford Motor Company, which converted its machinery to create face shields for hospitals in hot zones, including Detroit's Beaumont Health (see page 69). Ford is also using airbag material to make gowns that can be cleaned and reused.
- **The Other Industries** work group reached out to Coretrust members to vet alternative sources for needed supplies. These non-healthcare resources were able to help HealthTrust secure face shields, goggles, gloves, hand sanitizer, cleaning solutions and sanitizing wipes.
- **The PPE** workstream pursued bulk sources for personal protective equipment, including N95 respirators and other face masks, gowns (isolation, disposables, reusables), head and shoe coverings, and more. There were endless leads and brokers claiming to have products that never materialized.

  Given the shortages in PPE during the uncertain times, member facilities were being approached by countless manufacturers, distributors, brokers and agents offering PPE. HealthTrust advised that they exercise caution when evaluating those product sources and offered both written and live telephone guidance on how to accurately vet such leads.
- **The Pharmacy** work group moved a number of products to the controlled channel to protect inventory for member purchases and signed a number of new suppliers for priority medications used during intubations. The team continues to advise HealthTrust members on conservation strategies for critical drugs, such as sedatives and pain medications.
- **The Respiratory** workstream thoroughly reviewed and evaluated the viability and quality of ~70 products (ventilators, CPAPs, BiPAPs, disposables, etc.) from more than 60 suppliers, adding a number of them to contract for increased access. The team also created tools and resources for members that were shared with and used by the Federal Emergency Management Agency (FEMA).
- **The Virtual Warehouse** work group is stockpiling and distributing essential items through temporary warehouses located near members in three southern states. A number of colleagues were redeployed to pick up supplies and load trucks. **HT**

The power of PREDICTIVE

iStockphoto.com/ipopba

Data proves its value in everything from predicting surgical outcomes to securing PPE

MORE HOSPITAL SYSTEMS ARE TURNING TO HEALTH DATA ANALYTICS—not only as they struggle to cope with and plan for a pandemic, but also to gain valuable insights into overall operations and patient outcomes. Data analytics can use machine learning and artificial intelligence to glean information about everything from resource utilization to effective treatments and disease trajectories.

"Analytics is a big topic for us," says **Shay Bess**, M.D., an orthopedic spine surgeon at Denver International Spine Center and President of the International Spine Study Group, the nonprofit research foundation dedicated to advancing treatments for people with spine deformities—and one of the most productive

ANALYTICS

spine study groups in the world. Dr. Bess, a HealthTrust Physician Advisor, also works with the organization on some of its clinical data analytics initiatives.

ANTICIPATING PATIENT OUTCOMES

"It is an extraordinarily exciting time—to be able to use data not only to evaluate how patients are doing, but to predict how the patient is going to do," Dr. Bess says.

"We're learning more and more that we can predict how patients respond to nonoperative and operative approaches. And we can also predict what their responses will be on a health-related outcome measure in four to five years based on the intervention."

For instance, Dr. Bess notes, clinicians typically categorize patients with scoliosis as having "large" or "small" scoliosis. But analyzing data points can take it to another level.

Continued on page 24

Continued from page 23

The gush of data and information at the local, state, national and global levels is overwhelming. Using that data effectively is integral to success.

"The computer may see them as highly disabled or not disabled at all," Dr. Bess explains. The magnitude of their disease and its impact on their quality of life can determine treatment options and outcomes.

Using the patient's genotype, researchers can even predict whether patients are likely to develop an opioid addiction, while tissue and blood samples provide data to assess the patient's physiologic age, a better predictor of outcomes than chronological age.

Dr. Bess notes that one study compared how a surgeon predicted a patient's prognosis versus how the computer thought the patient would do. "The computer was much more accurate," he says.

"Analytics has turned upside down how we think about patients," says Dr. Bess. "It also shows us that the rudimentary criteria using rapidly outdated data is not going to work. There is a better way to evaluate patients."

DATA DURING A PANDEMIC

During this time of COVID-19, the gush of data and information at the local, state, national and global levels is overwhelming. Using that data effectively is integral to success.

HealthTrust is at the forefront of that effort, working with Dr. Bess to use analytics to estimate consumption rates for personal protective equipment (PPE), medications, and ICU and ventilator use for COVID-19 patients. The goal, Dr. Bess explains, is to predict consumption for individual hospitals based on volume and size so they can prepare for a surge in patients.

"If the algorithm shows that a specific hospital will have enough equipment, it may prevent a full shutdown of elective surgeries and other behavior changes," he says. That would be critical for hospitals, which are experiencing severe financial strain due to canceled elective surgeries and procedures during the pandemic.

However, Dr. Bess stresses that the human element is still critical in analyzing data. "Predictive analytics might get you from A to B quickly, but that might not be the right direction," he says. "It takes people collaborating to come up with the right questions to feed into the analytics program, which can then take us to the answer in a very quick and accurate fashion." **HT**

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HealthTrust Contract #500357

Instrumentation Laboratory
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Member health system CHRISTUS Health developed a new blood test to check for resistance to COVID-19 after infection—with results delivered in 10 minutes.

THE RACE for rapid results

Member hospitals create rapid tests for COVID-19, helping in the fight against the pandemic

WHEN COVID-19 DIAGNOSTIC TESTS ORIGINALLY BECAME AVAILABLE, it often took several days to get results. This delay posed myriad problems—namely, the potential for faster spread and higher rates of infection. Without immediate results, patients might not have adequately self-quarantined, and healthcare systems couldn't efficiently triage patients suspected of having the virus.

Two HealthTrust member hospitals began combating this problem in March and April by offering rapid-response tests that provided same-day results. (For a full list of sources for this article, please visit **healthtrustpg.com/RapidResults**.)

Continued on page 28

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HealthTrust Contract #7678

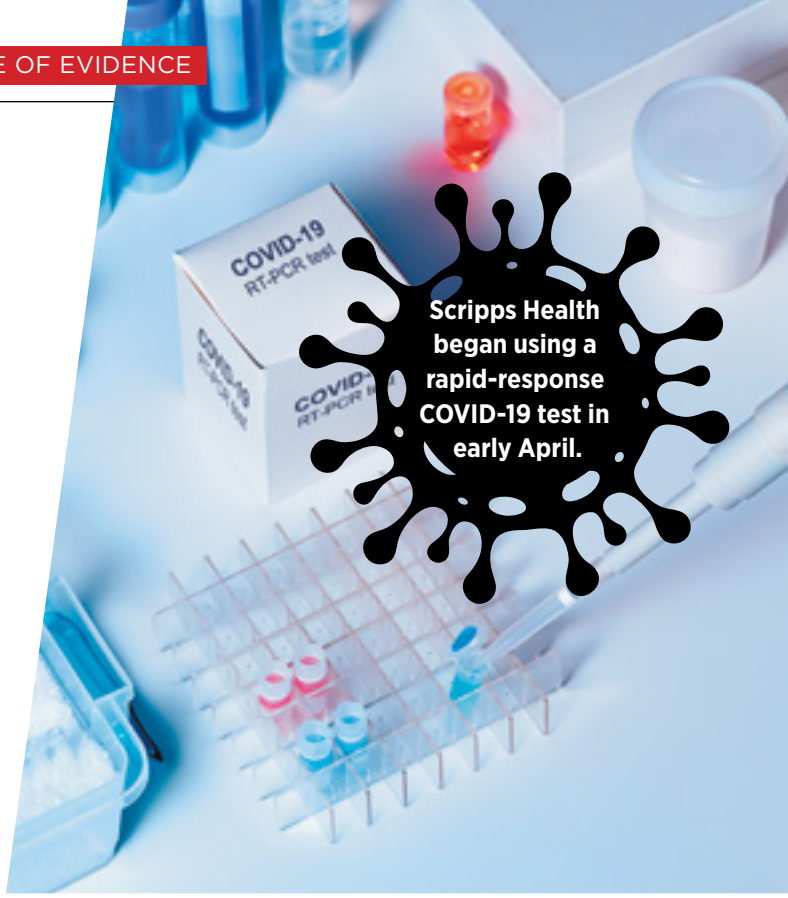
Continued from page 26

TESTS RAMP UP

According to a press release from Hackensack Meridian Health, the largest health network in New Jersey, its Center for Discovery and Innovation (CDI) received emergency use authorization from the Food and Drug Administration (FDA) in March for a rapid-response COVID-19 test. The test combines elements from others: one adopted by the World Health Organization (WHO) and one developed by the Centers for Disease Control and Prevention (CDC). Results are available within hours of testing.

As of May, Hackensack Meridian Health could test 24 patients every eight hours, a number they anticipated growing.

Scripps Health, a health system based in San Diego, also began using a rapid-response COVID-19 test at all five of its campuses in early April, according to its website. The test is conducted through Abbott Laboratories' "ID NOW" testing



MORE MEMBERS ARE PUT TO THE TEST

Other HealthTrust members are leading the way when it comes to testing innovation in the age of COVID-19.

Beaumont Health launches largest national study on serological testing. Through its Research Institute, Beaumont Health launched the country's largest study on serological blood testing, a test that detects antibodies. According to the Beaumont website, the study aims to answer many mysteries around COVID-19, including a better understanding of disease transmission, whether antibodies protect against reinfections, the scope of the total population affected by the disease and numbers around asymptomatic carriers. Long term, this research could also help inform a vaccination and reopening strategy. After initial results are revealed at the health system, the test will be available to other area hospitals.

RWJBarnabas Health Network partners with Rutgers University to make saliva-based tests available. Rutgers University developed a saliva test for COVID-19, allowing patients to avoid the discomfort of nose and throat swabs, reduce the risk of infection to healthcare workers during testing, and conduct a broader and a higher volume of screenings per day. According to Rutgers' website, the test was approved in April, and it was initially made available to the RWJBarnabas Health Network for use in the community.

FDA APPROVES TESTS PERFORMED ON MAILED-IN SAMPLES

In late April, the Food and Drug Administration (FDA) issued an emergency use authorization for a COVID-19 diagnostic test that can be done on samples that patients collect themselves at home.

The Laboratory Corporation of America (LabCorp) test requires that patients first complete an eligibility survey online. If they're deemed eligible, patients will receive a kit in the mail with materials to collect a nasal sample that they can mail in an insulated package to LabCorp to be tested.

Patients can file for insurance coverage or use federal funds to cover the cost.

LabCorp's at-home collection kits are available in many states and were expected to be available to most consumers by summer. Priority will be given to healthcare workers and first responders. However, it is important to note that because of the mailing time, total turnaround time is not necessarily quicker than a test performed within a healthcare facility.

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instrument, which had previously been used to detect the flu and strep throat. The ID NOW system can provide COVID-19 results in as little as five minutes.

As of May, Abbott was manufacturing 50,000 tests per day (around 1.5 million per month), and by June, it had shipped more than 3 million total tests.

Beyond testing for the virus itself, health organizations are working hard at discovering fast ways to test for immunity to the coronavirus. In April, member health system CHRISTUS Health developed a new blood test to check for resistance to COVID-19 after infection—with results delivered in 10 minutes. Offering immunity testing first to its staff and patients, the health system aimed to use the test to help workers feel safer testing patients. Its development could lead the way to more widespread, rapid immunity testing to help facilitate communities reopening.

A MATTER OF ACCURACY

Researchers from the Cleveland Clinic tested specimens positive for COVID-19 to determine which diagnostic tests were the most reliable. They found that Abbott Laboratories' ID NOW device detected the virus in 85.2% of the samples, meaning around 15% of patients would receive a false negative result. (Abbott has defended its test, citing that the detection rate could be skewed because samples were stored in a solution prior to being tested.)

For comparison, the CDC's official test, for which results take a few days, had a 100% detection rate. Another test from Cepheid, a molecular diagnostics company, which has a response rate within an hour, had a detection rate of 98.2%. **HT**

There's an APP for that!

Mobile apps from HealthTrust bring benefits to members & Physician Advisors

FOSTERING RELATIONSHIPS AND CONNECTING COMMUNITIES of people with similar specialties and interests are the objectives of two applications released recently by HealthTrust. Here are the tools and how members and Physician Advisors alike can benefit from them.

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HEALTHTRUST ADVISOR (MOBILE APP & ONLINE PLATFORM)

For: Members who wish to provide feedback on products
Why: Clinical Advisory Board members support HealthTrust's strategic sourcing process by bringing forth clinical evidence and sharing their clinical knowledge and experience when vetting products for possible addition to the HealthTrust contract portfolio. These members enhance the work of the internal Strategic Sourcing team by validating proposed contracting strategies, supporting final strategies, and driving compliance within their facilities and health systems once products are added to the HealthTrust portfolio.

The size of the Clinical Advisory Boards is limited. "However, by launching this mobile app and platform, all members can now provide feedback on products under review as well as suggest products for contract consideration," shares **Kim Kelly**, MSN, RN, Director, Clinical Categorization & HealthTrust Advisor App. This feedback is being incorporated into the sourcing process. The app provides these benefits to members:

- A direct line of communication to HealthTrust's Clinical Operations and Strategic Sourcing teams
- Two convenient ways to access (mobile app or online platform) via an email invite from HealthTrust
- The ability to submit new technologies as well as relevant trends and ideas on noncontracted products
- A weekly newsletter highlighting what's new as well as which Boards are soliciting feedback that week

The survey capabilities of the app are particularly useful when an Advisory Board Director wants to know which

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suppliers' products members are using in a particular contract category, to obtain quick feedback on the suppliers currently contracted in a category, and to hear from those making a potential product conversion about the perceived difficulty in moving from one supplier or product to another within a given category.

Kelly indicates: "We are in full launch mode at this point. The app and platform were initially tested with Advisory Board members and some non-Advisory Board members. The Clinical Operations team is working to expand the membership within the HealthTrust Advisor platform."

Members are encouraged to contact their HealthTrust Account Manager to express interest in joining this online community.

HEALTHTRUST COLLABORATIVES (MOBILE APP)

For: HealthTrust Physician Advisors (in the future, service line leaders, clinicians and attendees of HealthTrust's Collaborative Summit events will be engaged)

Why: HealthTrust started its Physician Advisor program in 2015. It has since grown to include 180 physicians in 42 specialties across 26 Integrated Delivery Networks (IDNs). According to **Todd DeVree**, AVP, Clinical Strategy, "The vision for our Physician Advisor app is to further elevate the physician's role in our activities by streamlining communications while also providing a platform for physicians to collaborate amongst one another outside of our organized calls and in-person meetings."

The app allows HealthTrust to easily gather physician feedback via surveys and polls, while also providing a platform to efficiently communicate opportunities for them to get more deeply involved in sourcing, member education or clinical evidence summaries. An exciting feature is the discussion boards that allow physicians to engage in peer-to-peer discussions about products and best practices in a secure environment. HealthTrust has enabled similar conversations in the past with panel discussions at educational events, but now the interactions will be ongoing.

Future plans for the app include engaging clinical leaders from various IDNs who want to share and learn best practices. This will include participants in our Collaborative Summits. These online communities launched after each summit will allow participants to engage beyond the on-site or virtual meetings on important healthcare topics. **HT**

HealthTrust COLLABORATIVES

Physician Advisors should contact Caroline Douglas, Manager, Physician Advisory Services, for assistance with the mobile app at caroline.douglas@healthtrustpg.com

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HealthTrust Contract #500173

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When virtual becomes REALITY

Telemedicine surges as a solution during the COVID-19 pandemic

IN MARCH 2020, AS HEALTHCARE ORGANIZATIONS AROUND THE U.S. prepared for the arrival of a highly contagious novel coronavirus predicted to overwhelm their facilities, many found a beacon in telemedicine. The technology hadn't broadly caught on yet, but it would prove to offer lifesaving solutions during a time of unprecedented challenges.

Prior to the pandemic, many medical facilities had been using telemedicine in small pockets for specific patient populations such as people living in rural areas or those with chronic conditions. Insurance companies would only reimburse for a limited number of services. Some people were concerned about privacy breaches, and others presumed it couldn't be as effective as a face-to-face visit.

CHANGES LEAD TO INNOVATION

The Centers for Medicaid & Medicare Services (CMS) responded to the crisis by widely expanding reimbursement for telemedicine. CMS also temporarily waived Health Insurance Portability and Accountability Act (HIPAA) violations against healthcare providers who serve patients in good faith through everyday communications technologies.

These two changes blew the door wide open for telemedicine. According to a late-April survey of 591 U.S. consumers by Black Book Market Research and Sage Growth Partners, more than one-third of people did not feel safe going to the doctor's office or a hospital, and the fear of COVID-19 made people more likely to use telehealth. More than half of survey respondents said they had access to telehealth.

Of those who had used telehealth, 78% were satisfied with their experience and 43% found their virtual visit to be as effective as an in-person visit.

SAFELY ADDRESSING IMPORTANT HEALTHCARE NEEDS

As the coronavirus took center stage in many areas of the country, people still needed care for the health issues they've always faced. For those patients concerned about going into high-risk areas like hospitals, telemedicine enables them to safely get remote care, such as checkups, consultations, post-surgical follow-ups, physical therapy, mental health services and more.

James Bruffey, M.D., is the Medical Director for spine care at Scripps Health in California and a HealthTrust Physician Advisor. Before the pandemic, the orthopedics department at Scripps was in the process of piloting telemedicine within Epic. In March, as virus exposures increased in the area, caseload was low. "Patients were concerned about being exposed, but they still needed access to care," says Dr. Bruffey. "We had to quickly come up with a way to provide that care safely, so we rolled it out."

Patients are relieved to be able to connect with a physician during this time, notes Dr. Bruffey. "If it's a normal two-month post-op visit, patients love it because they don't have to drive in, they get to see me and it's very efficient."

At Franciscan Alliance, a Midwestern health system, telemedicine was only used before the coronavirus for the accountable care organization. During the pandemic, telemedicine was expanded to orthopedics and other departments. HealthTrust Physician Advisor **William Payne**, M.D., an orthopedic surgeon with Franciscan Alliance says, "Patients

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MEMBER CASE STUDY: MERCY VIRTUAL CARE CENTER

Because of the growing shortage of caregivers and spiraling medical costs, Mercy, a health system serving Missouri, Oklahoma, Arkansas and Kansas, invested heavily in telemedicine and is now touching lives across the nation. The health system opened its Mercy Virtual Care Center in 2015 in Chesterfield, Missouri. Healthcare professionals work at the center and monitor patients remotely. At least 13 services are offered—from virtual observation to stroke diagnosis.

The vEngagement program supports high-risk patients with chronic conditions. These patients are given a tablet device, blood pressure cuff, pulse oximeter and weight scale. Under the direction of a primary care provider, patients are monitored daily.

Another program called vAcute is essentially a virtual emergency services department (ED) for people who live in rural or remote areas where there may be a shortage of healthcare providers. A team of ED physicians and nurses can assess and treat patients in the moment. They coordinate with local EDs, hospitals and skilled nursing facilities to ensure patients are routed appropriately if additional care is needed.

In March, Mercy quickly set up COVID-19 screening, testing and treatment. "Our nurse-on-call virtual service was opened up not only to Mercy facilities, but to any patient anywhere who needed to be tested," says **Kellie Matusofsky**, RN, BSN, Director of vEngagement and vAcute services at Mercy. They virtually monitor these patients via a texting platform for 14 days. If a patient's symptoms worsened, the staff knew and could help.

Because the system already had so much technology in place, providers had a major head start in knowing what works effectively in a crisis. "We've been able to leverage existing technology and quickly deploy additional technology for our patients, as well as enhance the support we provide our partner sites," explains **Krista McKenzie**, MSN, RN, NE-BC, Executive Director of Virtual Operations at Mercy.

Mercy Virtual has been educating staff in traditional in-person clinics on how to do virtual medicine. While it's a change in their practice, they're still able to see their patients and provide the same level of care.

"Putting an ICU doctor in front of a screen feels strange at first," notes McKenzie. "But taking care of a patient has a lot to do with listening and hearing about symptoms and how someone is feeling. You can treat them in the same manner with the same outcome."

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1. http://www.stopwaste.org/sites/default/files/Documents/toner.pdf
2. https://energycentral.com/c/ec/ink-waste-environmental-impact-printer-cartridges

Continued from page 35

generally like being able to see their doctor, and providers gain information because human emotions and facial expressions are available."

VIRTUAL SCREENING & TREATMENT

When it comes to treating COVID-19, telemedicine enables healthcare professionals to conduct a video screening with people in their homes who think they may have contracted the virus. The healthcare provider asks patients questions and has them take their temperature. If symptoms are present, the provider will authorize a test.

In many cases, people who are sick at home with COVID-19 can be safely monitored and treated virtually. Patients can exchange daily texts with providers and submit temperature readings. Telemedicine helps slow the spread of the COVID-19 infection to healthcare workers and other people coming into emergency departments or physician offices.

AVOIDING PITFALLS

With all of the benefits of telemedicine, there is also a learning curve for patients and staff. The technology is generally reliable, but limited internet bandwidth at home can make the connection spotty. Patients may need help from loved ones when using the phone or computer during a visit—for example, to help show an injury in a hard-to-reach area, so the physician can get a good look. Or a patient may need to obtain a medical device, such as a blood pressure cuff or pulse oximeter, and be taught how to use it at home.

"People over the age of 75 sometimes have concerns about technology, so we try to engage a daughter or son to help walk them through the process," adds Dr. Payne.

A NEW WORLD

"The ability to deliver care to people at home is the transformation that medicine is seeking," says Dr. Payne. "Once patients get a taste, they will accept it as part of everyday life."

Dr. Bruffey agrees that his team will continue to use telemedicine even after the pandemic. "I look forward to its evolution," he adds. **HT**

TELL US HOW telemedicine is transforming your practice or how it has evolved during the COVID-19 pandemic by sharing your story at thesource@healthtrustpg.com

The Source reader survey results

Below are highlights from the reader survey initiated after the publication of the Q4 2019 edition.

Overall Opinion
"Excellent" or "Very Good"

Content or Information
"Excellent" or "Very Good"

New Appearance
"Excellent" or "Very Good"

78% consider *The Source* very or somewhat relevant to their professional role.

The topics that generated the highest total levels of interest are:

- **Improving healthcare**
- **Innovation & healthcare technology**
- **HealthTrust products & services**
- **Industry & HealthTrust news**

51% of respondents report that they share the entire publication or articles/ads of interest with others. The print distribution of ~14,486 reaches another "pass-along" audience of 7,380, for a total reach of about 21,866 readers.

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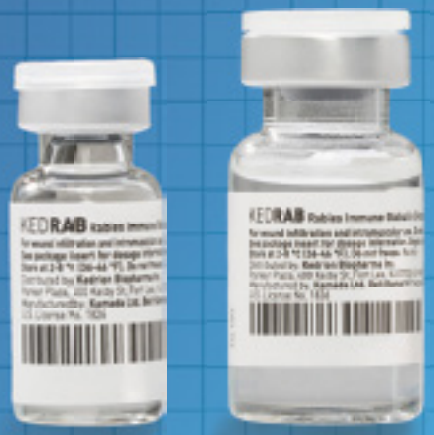
- **No need for dilution with dextrose[1]**
  - **May help reduce the potential for errors caused by the need to prepare an admixture[3]**



2-mL vial/300 IU
NDC 76125-150-02

10-mL vial/1500 IU
NDC 76125-150-10

INDICATIONS AND USAGE

KEDRAB® (Rabies Immune Globulin [Human]) is a human rabies immunoglobulin (HRIG) indicated for passive, transient post-exposure prophylaxis (PEP) of rabies infection, when given immediately after contact with a rabid or possibly rabid animal. KEDRAB should be administered concurrently with a full course of rabies vaccine.

- Additional doses of KEDRAB should not be administered once vaccine treatment has been initiated, since this may interfere with the immune response to the rabies vaccine.
- KEDRAB should not be administered to patients with a history of a complete pre-exposure or post-exposure vaccination regimen and confirmed adequate rabies antibody titer.

IMPORTANT SAFETY INFORMATION

- Patients who can document previous complete rabies pre-exposure prophylaxis or complete post-exposure prophylaxis should only receive a booster rabies vaccine without KEDRAB, because KEDRAB may interfere with the anamnestic response to the vaccine (ACIP).

KEDRAB®
Rabies Immune Globulin (Human)

HealthTrust Contract #51666
For more information visit KEDRAB.com

IMPORTANT SAFETY INFORMATION (CONTINUED)

- KEDRAB should not be injected into a blood vessel because of the risk of severe allergic or hypersensitivity reactions, including anaphylactic shock. KEDRAB can induce a fall in blood pressure associated with an anaphylactic reaction, even in patients who tolerated previous treatment with human immunoglobulin. KEDRAB should be discontinued immediately if there is an allergic or anaphylactic type reaction. In case of shock, standard medical treatment should be implemented. Epinephrine should be available.
- Patients with a history of prior systemic allergic reactions following administration of human immune globulin preparations should be monitored for hypersensitivity. KEDRAB contains a small quantity of IgA. Patients who are deficient in IgA have the potential to develop IgA antibodies and may have anaphylactic reactions following administration of blood components containing IgA. The healthcare provider should assess the risks of this reaction against the benefits of administering KEDRAB.
- Patients at increased risk of thrombosis or thrombotic complications should be monitored for at least 24 hours after KEDRAB administration.
- Hemolysis may occur in patients receiving immune globulin products, particularly those who are determined to be at increased risk. Clinical symptoms and signs of hemolysis include fever, chills and dark urine. If any of these occur, appropriate laboratory testing should be performed and medical therapy administered as indicated.
- KEDRAB administration may interfere with the development of an immune response to live attenuated virus vaccines. After KEDRAB administration, immunization with measles vaccine should be avoided within 4 months; other live attenuated virus vaccines avoided within 3 months.
- A transient rise of the various passively transferred antibodies in the patient's blood may result in misleading positive results of serologic tests after KEDRAB administration. Passive transmission of antibodies to erythrocyte antigens may interfere with serologic tests for red cell antibodies such as the antiglobulin test (Coombs' test).
- KEDRAB is derived from human plasma; therefore, the potential exists that KEDRAB administration may transmit infectious agents such as viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. There is also the possibility that unknown infectious agents may be present in KEDRAB.
- In clinical trials, the most common adverse reactions in subjects treated with KEDRAB were injection site pain (33%), headache (15%), muscle pain (9%), and upper respiratory tract infection (9%).

Please see Brief Summary of Prescribing Information on the next page.

KEDRAB Dose Calculator

Access the online calculator: 1. Scan the QR code with the camera on your phone.
2. Open the link to access or visit **KEDRABDoseCalculator.com**.

References: 1. KEDRAB [package insert]. Fort Lee, NJ: Kedrion Biopharma Inc.; 2017. **2.** Scott D. Scientific basis for approval of human rabies immune globulin in combination with rabies vaccine. Presented at: Developing Rabies Monoclonal Antibody Products as a Component of Rabies Post-Exposure Prophylaxis; July 17, 2017; Silver Spring, MD. **3.** Billsten-Leber M, Carrillo CJD, Cassano AT, Moline K, Robertson JJ. ASHP Guidelines on Preventing Medication Errors in Hospitals. *Am J Health Syst Pharm*. 2018; 75:1493-1517. doi: 10.2146/ajhp170811.

KEDRION BIOPHARMA

KEDRAB Rabies Immune Globulin (Human)

BRIEF SUMMARY OF
FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

KEDRAB is a human rabies immunoglobulin (HRIG) indicated for passive, transient postexposure prophylaxis (PEP) of rabies infection, when given immediately after contact with a rabid or possibly rabid animal. KEDRAB should be administered concurrently with a full course of rabies vaccine. Do not administer additional (repeat) doses of KEDRAB once vaccine treatment has been initiated, since this may interfere with the immune response to the rabies vaccine. Do not administer KEDRAB to patients with a history of a complete pre-exposure or post-exposure vaccination regimen and confirmed adequate rabies antibody titer.

WARNINGS AND PRECAUTIONS

Previous Rabies Vaccination: Patients who can document previous complete rabies pre-exposure prophylaxis or complete post-exposure prophylaxis should only receive a booster rabies vaccine without KEDRAB, because KEDRAB may interfere with the anamnestic response to the vaccine (ACIP). **Anaphylactic Shock:** KEDRAB should not be injected into a blood vessel because of the risk of severe allergic or hypersensitivity reactions, including anaphylactic shock. KEDRAB can induce a fall in blood pressure associated with an anaphylactic reaction, even in patients who tolerated previous treatment with human immunoglobulin. Discontinue KEDRAB injection immediately if there is an allergic or anaphylactic type reaction. In case of shock, implement standard medical treatment. Epinephrine should be available for treatment of acute anaphylactic symptoms. **Hypersensitivity:** Patients with a history of prior systemic allergic reactions following administration of human immune globulin preparations should be monitored for hypersensitivity. KEDRAB contains a small quantity of IgA. Patients who are deficient in IgA have the potential to develop IgA antibodies and may have anaphylactic reactions following administration of blood components containing IgA. The healthcare provider should assess the risks of this reaction against the benefits of administering KEDRAB. **Thrombosis:** Patients at increased risk of thrombosis or thrombotic complications should be monitored for at least 24 hours after KEDRAB administration. Patients at increased risk of thrombosis include patients with acquired or hereditary hypercoagulable states, prolonged immobilization, in-dwelling vascular catheters, advanced age, estrogen use, a history of venous or arterial thrombosis, cardiovascular risk factors (including history of atherosclerosis and/or impaired cardiac output), and hyperviscosity syndromes (including cryoglobulinemias, fasting chylomicronemia and/or high triglyceride levels, and monoclonal gammopathies). Consider measurement of baseline blood viscosity in patients at risk for hyperviscosity. **Hemolysis:** Hemolysis may occur in patients receiving immune globulin products, particularly those who are determined to be at increased risk. Patients at increased risk include those with non-O blood group types, those with underlying associated inflammatory conditions, and those receiving high cumulative doses of immune globulins over the course of several days. Clinical symptoms and signs of hemolysis include fever, chills and dark urine. If any of these occur, perform appropriate laboratory testing and administer medical therapy as indicated. **Live Attenuated Virus Vaccines:** KEDRAB administration may interfere with the development of an immune response to live attenuated virus vaccines. Avoid immunization with measles vaccine within 4 months after KEDRAB administration. Avoid immunization with other live attenuated virus vaccines within 3 months after KEDRAB administration. **Interference with Serologic Testing:** A transient rise of the various passively transferred antibodies in the patient's blood may result in misleading positive results of serologic tests after KEDRAB administration. Passive transmission of antibodies to erythrocyte antigens, e.g., A, B, and D, may interfere with serologic tests for red cell antibodies such as the antiglobulin test (Coombs' test). **Transmissible Infectious Agents:** KEDRAB is derived from human plasma; therefore, the potential exists that KEDRAB administration may transmit infectious agents such as viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. The risk of transmitting an infectious agent has been minimized by: Screening plasma donors for prior exposure to certain viruses; Testing for certain viral infections; Inactivating and removing certain viruses during the manufacturing process [see *Description* in the Full Prescribing Information]. Despite these measures, KEDRAB administration can still potentially transmit infectious diseases. There is also the possibility that unknown infectious agents may be present in KEDRAB. Any infection considered to have possibly been transmitted by this product should be reported by the physician or other healthcare provider to Kedrion Biopharma Inc. Customer Service (1-855-353-7466) or FDA at 1-800-FDA-1088.

ADVERSE REACTIONS

Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates of adverse reactions in clinical trials of another drug and may not reflect the rates observed in clinical practice. KEDRAB was evaluated in three single-center, controlled clinical trials. Subjects in the clinical studies of KEDRAB were healthy adults, primarily white and ranged in age from 18 to 72 years. A total of 160 subjects were treated in these three studies, including 91 subjects who received single intramuscular doses of KEDRAB (20 IU/kg) with or without rabies vaccine. Table 1 summarizes adverse events (assessed by the investigator as related or unrelated to study treatment) occurring in >3% of subjects in the clinical trials of KEDRAB. The most frequent adverse events in the KEDRAB group (>6%) were injection site pain, headache, muscle pain, and upper respiratory tract infection (Table 1). **Table 1: Adverse Events Occurring in >3% of Subjects in All Studies Combined** (91 subjects receiving KEDRAB vs. 84 subjects receiving Comparator HRIG vs. 8 subjects receiving Saline Placebo + Vaccine). Data are presented as number of subjects (% of subjects). Injection site pain, 30 (33), 26 (31), 2 (25); Headache, 14 (15), 11 (13), 3 (38); Muscle pain, 8 (9), 6 (7), 0; Upper respiratory tract infection, 8 (9), 8 (10), 0; Joint pain, 5 (6), 0, 1 (13); Dizziness, 5 (6), 3 (4), 0; Fatigue, 5 (6), 2 (2), 0; Abdominal pain, 4 (4), 1 (1), 0; Blood in urine, 4 (4), 2 (2), 0; Nausea, 4 (4), 3 (4), 0; Feeling faint, 4 (4), 1 (1), 0; Bruising, 3 (3), 1 (1), 0; Sunburn, 3 (3), 0, 0; White blood cells in urine, 3 (3), 4 (5), 0. Less common adverse events were joint pain, dizziness, fatigue, abdominal pain, blood in urine, nausea, feeling faint, bruising, sunburn, and white blood cells in urine.

DRUG INTERACTIONS

Do not administer additional (repeat) doses of KEDRAB once vaccination has been initiated, since additional doses of KEDRAB may interfere with the immune response to the vaccine. Do not administer KEDRAB into the same anatomical site(s) as rabies vaccine. KEDRAB contains other antibodies that may interfere with the response to live vaccines such as measles, mumps, polio or rubella. Avoid immunization with live virus vaccines within 3 months after KEDRAB administration, or in the case of measles vaccine, within 4 months after KEDRAB administration [see *Warnings and Precautions / Live Attenuated Virus Vaccines*].

USE IN SPECIFIC POPULATIONS

Pregnancy: *Risk Summary*. KEDRAB has not been studied in pregnant women. Therefore, the risk of major birth defects and miscarriage in pregnant women who are exposed to KEDRAB is unknown. Animal developmental or reproduction toxicity studies have not been conducted with KEDRAB. It is not known whether KEDRAB can cause harm to the fetus when administered to a pregnant woman or whether KEDRAB can affect reproductive capacity. In the U.S. general population, the estimated background of major birth defects occurs in 2-4% of the general population and miscarriage occurs in 15-20% of clinically recognized pregnancies. **Lactation:** *Risk Summary*. There is no information regarding the presence of KEDRAB in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for KEDRAB and any potential adverse effects on the breastfed infant from KEDRAB or from the underlying maternal condition. **Pediatric Use:** The safety and effectiveness of KEDRAB in the pediatric population have not been established. **Geriatric Use:** Clinical studies of KEDRAB did not include sufficient numbers of subjects aged 65 years and over to determine whether they respond differently from younger subjects. Clinical experience with HRIG products has not identified differences in effectiveness between elderly and younger patients (ACIP).

NONCLINICAL TOXICOLOGY

Animal Toxicology and/or Pharmacology: Intramuscular administration of a single dose of KEDRAB to rats at 60 and 120 IU/kg (3-fold and 6-fold higher than the recommended human dose of 20 IU/kg), did not result in any signs of toxicity.

For a copy of the Full Prescribing Information for KEDRAB, please visit www.KEDRAB.com.

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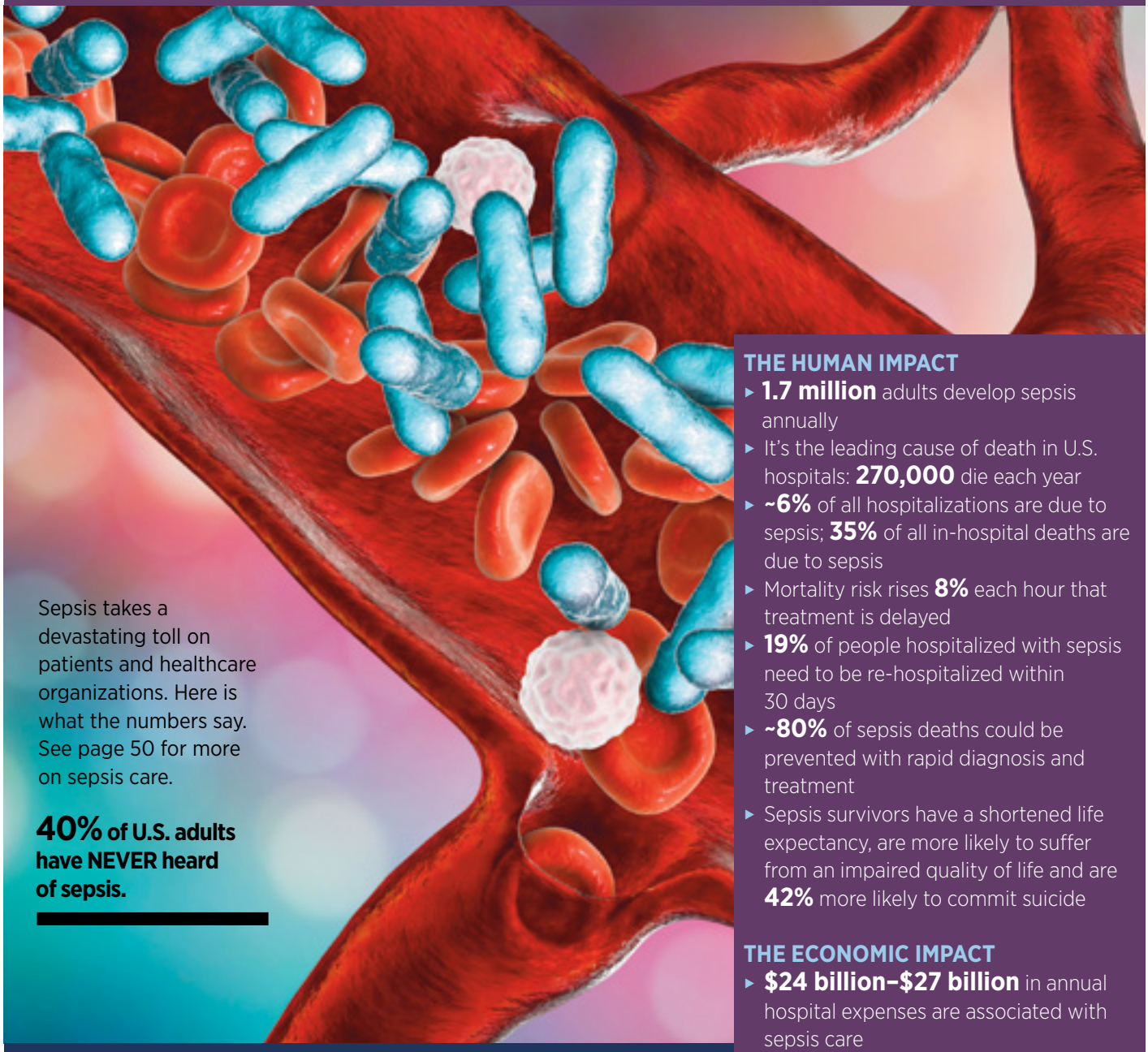
January 2018 KR-0562-00-2018B

FOCUS ON SEPSIS



Sepsis takes a devastating toll on patients and healthcare organizations. Here is what the numbers say. See page 50 for more on sepsis care.

40% of U.S. adults have NEVER heard of sepsis.

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Sepsis symptoms include:

S – Shivering, fever or very cold
E – Extreme pain or general discomfort ("worst ever")
P – Pale or discolored skin
S – Sleepy, difficult to rouse, confused
I – "I feel like I might die"
S – Shortness of breath

THE HUMAN IMPACT

- **1.7 million** adults develop sepsis annually
- It's the leading cause of death in U.S. hospitals: **270,000** die each year
- **~6%** of all hospitalizations are due to sepsis; **35%** of all in-hospital deaths are due to sepsis
- Mortality risk rises **8%** each hour that treatment is delayed
- **19%** of people hospitalized with sepsis need to be re-hospitalized within 30 days
- **~80%** of sepsis deaths could be prevented with rapid diagnosis and treatment
- Sepsis survivors have a shortened life expectancy, are more likely to suffer from an impaired quality of life and are **42%** more likely to commit suicide

THE ECONOMIC IMPACT

- **$24 billion–$27 billion** in annual hospital expenses are associated with sepsis care
- No. 1 cause for hospital readmissions, costing **>$2 billion** annually
- **$18,400** = the average cost per hospital stay for sepsis; double the per-stay cost across all other conditions

Source: Sepsis Alliance Fact Sheet Downloads/Sepsis-Fact-Sheet-2018%20(1).pdf

Hospital favorability ratings increased since the pandemic began from 73% in June 2013 to 86% in April 2020.

Trust has increased in nurses by 73%, in doctors by 71% and in hospitals by 68%.

Source: Jarrard survey data

STRATEGIZING during a pandemic

How healthcare facilities across the nation are overcoming countless challenges—and what comes next

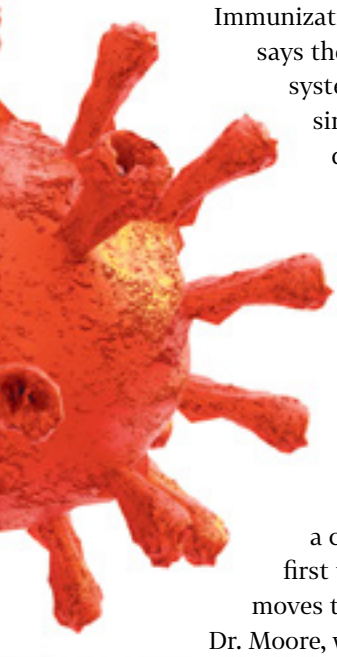
THE COVID-19 PANDEMIC IS THE ONE OF THE BIGGEST HEALTH EVENTS to ever hit our country. The public is counting on hospitals now more than ever—and they're stepping up. Not only have hospital favorability ratings increased since the pandemic began (from 73% in June 2013 to 86% in April 2020), but the general public's trust in hospitals has also risen, according to recent survey data from Jarrard, a healthcare communications and consulting firm. Trust has increased in nurses by 73%, in doctors by 71% and hospitals by 68%.

From major academic medical centers to small community hospitals, healthcare facilities across the nation have risen to the occasion by fighting the pandemic all while keeping their providers and patients safe. So, what have we learned?

HealthTrust members and Physician Advisors weigh in on some of the challenges they've seen, how they're combating them, and how this pandemic has changed the face of both traditional and emergency planning for years to come.

BRACING FOR THE UNKNOWN

HealthTrust Physician Advisor **Kelly Moore**, M.D., MPH, President of The Vaccine Advisor and Associate Director of Immunization Education with the Immunization Action Coalition, says the biggest challenge most health systems faced early on in the pandemic was simply fear of the unknown—experts didn't understand the case fatality rate or all the ways in which the virus could be transmitted, among many other mysteries.



Health systems not only worried about whether they'd have enough tests and personal protective equipment (PPE), but also how to treat patients who tested positive for the virus.

"It's like we're playing chess against a completely unknown opponent for the first time, and that opponent has surprising moves that create great challenges for us," says Dr. Moore, who is based in Nashville, Tennessee. She previously oversaw the pandemic response plan and immunization program for the state of Tennessee.

HealthTrust Physician Advisor **Bryan Fisher**, M.D., Chief of Vascular Surgery at TriStar Centennial Medical Center in Nashville, Tennessee, adds that the lack of testing early on made it difficult to identify who had the virus, creating a host of problems. "We didn't really have a great gauge of where to start," he says. "The only way to mitigate what we were anticipating was obviously to take very austere measures and limit the number of patients in the hospital."

And as health systems across the nation gained more knowledge about the virus and testing became more available, the challenge shifted from fear of the unknown to facing concrete problems head on. While large medical centers in urban areas like New York City, Chicago and Los Angeles had pressing challenges, smaller community hospitals had their own set of obstacles, says **Christopher Rehm**, M.D., Chief Medical Officer at LifePoint Health—a system based in Brentwood, Tennessee, that operates 88 community hospitals across the country.

"While we might not be in a large metropolitan area that has community spread, COVID-19 has still put our hospitals under stress," Dr. Rehm says. For instance, one LifePoint facility—Sumner Regional Medical Center in Gallatin, Tennessee—saw more than 100 COVID-19-related visits in one weekend from a nearby nursing home well before community spread began in that area.

"We're not in the middle of a city with a population of millions, but we do have clusters of vulnerable populations living in long-term care environments, which can be a source of a surge."

REACTING TO THE REALITIES

In light of the uncertainties and daily challenges, hospital systems have had to pivot their priorities and find new and innovative ways to serve their patients. Here are some of the biggest hurdles hospitals have faced during the COVID-19 pandemic:

Elective surgeries

Following federal- and state-mandated orders, most healthcare institutions began postponing elective surgeries in mid-March to preserve resources and ICU beds in the event of a surge in COVID-19 cases.

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At TriStar, Dr. Fisher says elective vascular surgery cases, such as endarterectomies for asymptomatic carotid disease, nonurgent aneurysm repairs, angioplasty for lifestyle-limiting claudication and AV fistula placement for new dialysis access, were all postponed.

Most healthcare facilities have phased elective surgeries back in with an emphasis on close preoperative observation. For example, LifePoint hospitals have patients monitor their temperature in the week leading up to surgery, and then test patients for COVID-19 before surgery.

At LifePoint, surgeries are slowly being phased back in based on the COVID-19 situation at each hospital, says Chief Nursing Officer **Michelle Watson**, RN, MSN. "It's very controlled," she says. "It's not something that just opens all at once."

Supply chain & pharmacy management

Lack of PPE and essential drugs was a major concern for most medical institutions at the beginning of the pandemic.

Dr. Fisher says, luckily, TriStar has not seen a break in the supply chain, in part because it took conservative measures early on in order to preserve resources. "I don't think we're really at risk of running out of supplies," he says. "Having a network of eight hospitals, you can aggregate resources almost in real-time and be nimble enough to make changes for each individual hospital."

Dr. Rehm says LifePoint is in a similar situation, as it can freely move supplies among its 88 facilities. "We've had the ability to look at pharmaceuticals, PPE and even ventilators from the perspective of: If we need to, can we move them around based on where this is impacting us?" he says.

Early on, there was ample concern about shortages in intravenous pain-control medications and paralytics for patients with COVID-19 in the ICU. Dr. Rehm explains that to prepare for this potential shortage, LifePoint's pharmacy director provided educational resources on equivalent drugs that were just as effective while supply chain staff worked on securing both the primary medications and their alternatives.

Staffing

COVID-19 has presented a learning curve for nurses, physicians and other medical personnel who have been deployed into new roles. Watson explains that operating room nurses who were no longer working on elective surgeries, for example, had to learn new workflows when deployed to different units. Some physicians who had worked in an outpatient setting for years now had to adapt to working with patients in a hospital environment.

HealthTrust Physician Advisor **William Sistrunk**, M.D., FACP, an infectious disease physician with Mercy Health in Springfield, Missouri, and Clinical Vice President of Mercy Lab, says his system faced staffing issues, but in a less traditional sense. The pandemic hit right around the time of spring break. The Centers for Disease Control and Prevention (CDC) had begun recommending that people who visited certain countries voluntarily quarantine upon returning to the U.S.

"We had a lot of staff who were out. We were short on emergency room physicians, ICU nurses and other providers in a lot of different pockets," he says. To respond, they moved providers and coworkers from other areas to help care for patients and used telemedicine to supplement care.

MOVING FORWARD

HealthTrust Physician Advisor **Pete Brookmeyer**, M.D., an infectious disease specialist with Centura Health in Colorado Springs, Colorado, says he believes one big lesson health systems have learned from the COVID-19 pandemic is the necessity of a robust stockpile.

"I think there needs to be some kind of central stockpile at larger institutions, so we have enough supplies that get rotated out periodically and don't expire," he says.

Continued on page 48

> "We've had the ability to look at pharmaceuticals, PPE and even ventilators from the perspective of: If we need to, can we move them around based on where this is impacting us?"
>
> – Christopher Rehm, M.D.

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[1] https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

PATIENT CARE INTERVENTIONAL CARE **ENVIRONMENT OF CARE**

Continued from page 46

Dr. Sistrunk agrees, adding that facilities will also need to think more about storage space moving forward. Most health systems don't have warehouses, and storage space can be expensive. "That's a continued cost, which is why health systems don't just buy pandemic PPE supply," he says. "It's a challenge."

Dr. Rehm and Watson say COVID-19 has highlighted the importance of providing front-line staff with everything they need to thrive.

"The length of this pandemic and keeping people resilient is a new aspect we've incorporated into emergency preparedness that I can't imagine will go away in the future," Dr. Rehm says.

Dr. Fisher believes the COVID-19 pandemic has demonstrated that having efficient communication within a health system is vital. (See "Straight talk: communicating during a crisis" on page 63.) "We've seen that from an organizational standpoint," he notes. "When you have a crisis come through, you have to be prepared at different levels. You have to communicate if you want to end up succeeding."

Dr. Moore agrees, noting how essential it is to do thorough emergency and traditional response planning ahead of time—not in the midst of a crisis. "My hope is that this virus and the severity of it will hold us accountable in our planning processes in a way that we weren't always accustomed to in the past," she adds. **HT**

A DISCRIMINATING DISEASE

The COVID-19 pandemic shines a light on healthcare inequities in the Black community. Even though Chicago's Black community accounts for only 29% of the city's total population, 72% of the city's COVID-19-related deaths have been in the Black population. This trend has been seen across the country.

"This virus is exploiting disparities and vulnerabilities in our communities," Dr. Moore explains. "Infectious diseases frequently run along the rift line of society. The people who fall through the cracks are often the most vulnerable to infectious diseases, and COVID-19 is no different. It's exposing disparities in access to care and health status that have existed for a long time. That's being reflected in the disparate impact on the African-American community."

FOR MORE INFORMATION on optimizing your supply chain, contact Drew Preslar, AVP Supply Chain Advisory Solutions, at drew.preslar@healthtrustpg.com

THE NEED FOR A VACCINE

Dr. Moore says the COVID-19 pandemic's end hinges on having an effective vaccine. "This is far from over," she says. "The end game for this pandemic is likely not to occur until we get an effective vaccine and have that deployed."

There are currently over 100 candidate vaccines being evaluated around the world, she says. "What we have to remember is that most candidate vaccines fail and don't actually make it to fruition," Dr. Moore explains. "We'll be lucky if we have one or two good vaccines that have demonstrated effectiveness against the virus that make it to production."

Experts have discussed the possibility of a vaccine coming to market in around 18 months. Dr. Moore says this is an incredibly foreshortened timeline. The entire process—from deciding to make a vaccine to having the vaccine on the market—typically takes 10 years or longer.

To expedite the process, labs and companies that typically work in silos have begun working together. "You have these creative collaborations and an enormous commitment to rolling out something as quickly as possible," Dr. Moore adds. "But no matter how quickly you go, and no matter how many studies you run through concurrently to save time, you still have steps you cannot skip to ensure a vaccine is safe and will work the way it's intended to work."

One strategy being discussed, she says, is scaling up the production of a vaccine before we know if it works to have a stockpile that can be distributed as soon as possible in order to expedite access to the vaccine.

"We have to remember that this is science, and many experiments in science have a negative result," Dr. Moore says. "We have to work hard and quickly, but we need to be aware that we're learning. The most important thing for health systems in the meantime is being prepared to respond to the virus using the lessons we've already learned."

Dr. Fisher, who is on the Advisory Board for the National Minority Quality Forum (NMQF), says it's no surprise the pandemic has highlighted this gap in access to care. "One can imagine that when you have a strain on the system, it's going to have an adverse effect and be magnified," he says. He explains that only some of the early COVID-19 data shows that the higher mortality rate in the Black population is due to comorbidities, suggesting that the increase is due also to the age-old healthcare imbalance in the Black community.

The NMQF has collaborated closely with the Congressional Black Caucus and other members of Congress to combat this issue through testing and education, Dr. Fisher says.

Dr. Fisher hopes the pandemic has provided enough momentum to finally address these issues head-on so meaningful change can occur to correct the imbalance in healthcare. "I think America is really at a reckoning," he says. "When you see people who might not look like you getting sick and dying—and they're in your country, in your state and in your city—that's alarming. I hope this sparks a change."

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SEPSIS CARE across the continuum

Protocols improve detection & treatment, but transition of care remains a challenge

IT'S THE LEADING CAUSE OF DEATH IN U.S. HOSPITALS, according to the Centers for Disease Control and Prevention (CDC). With every hour that passes before treatment begins, mortality risk jumps nearly 8%. These statistics demonstrate that sepsis continues to pose serious challenges for facilities across the country, specifically when it comes to effectively transitioning care from unit to unit and from hospital to home.

Sepsis care across the continuum was to be the focus of HealthTrust's Collaboration Summit meeting in late April, but the two-day event was postponed due to the COVID-19 pandemic.

Despite public awareness campaigns drawing greater attention to sepsis, which strikes about 1.7 million adults each year and kills 270,000, many don't realize the condition's stark toll, experts say. But healthcare organizations across the nation have ramped up efforts in recent years to both cut the mortality rate and peel back some of the more than $24 billion in annual hospital expenses associated with sepsis care.

"In the last five years, various protocols for diagnosis and treatment have started to gain traction, and hospitals started looking closely at having a staff member specifically focused on sepsis," explains **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research & Education for HealthTrust. "Sepsis coordinators look at every case, when cases are triggered, what actions are taken and what appropriate actions would be, as well as the response."

"The ability to bend the survival curve hinges on early detection and coordination of care," says **Jeffrey S. Guy**, M.D., MS, MMHC, FACS, Vice President of Clinical

Healthcare organizations across the nation have ramped up efforts in recent years to both cut the mortality rate and peel back some of the more than $24 billion in annual hospital expenses associated with sepsis care.

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Services for HCA Healthcare in Nashville, Tennessee, and a HealthTrust Physician Advisor. "Detecting when patients get infections and giving a few dollars' worth of antibiotics and IV fluids can change outcomes dramatically," Dr. Guy says. "It's about getting the basics down well."

EVOLVING DIAGNOSTIC TOOLS

Because cost and length of hospital stay rise progressively with the severity of sepsis, healthcare leaders have increasingly focused on protocols surrounding early detection and treatment. But varying definitions of sepsis itself have created a speed bump on the path toward standardizing treatment, Bush notes. U.S. clinicians currently can choose from three options to define patients presenting with suspected sepsis, including a version advanced by the Centers for Medicare & Medicaid Services (CMS).

Regardless of definition, diagnosing sepsis typically takes into account factors such as patient temperature; heart and respiration rate; white blood cell count; blood pressure; lactate levels, which can show a lack of oxygen; and creatinine levels, which can measure kidney function.

Meanwhile, the latest tool to identify poor outcomes in sepsis patients is known as the quick Sepsis Related Organ Failure Assessment, or qSOFA, Bush says. A bedside prompt that may identify patients with suspected infection at greater risk for a poor outcome without ICU care, the qSOFA score uses three criteria: low blood pressure, high respiratory rate or altered mentation.

Still, these tools don't always provide the full picture. "Recognizing sepsis is going to take more than putting together criteria," says HealthTrust Physician Advisor **S. Shaefer Spires**, M.D., an infectious disease specialist at Duke Health in Durham, North Carolina. "Research is burgeoning and people are thirsting for it, with revelations on new biomarkers and the understanding around which lab values mean more than others in detection and treatment.

"We're all scrambling in situations where we're not sure what's causing sepsis," he adds, "and we end up doing something—and everything—as physicians" to treat it.

HCA Healthcare was recently recognized for "SPOT," its innovative approach to detecting sepsis using artificial intelligence. Learn more about SPOT in our upcoming Q4 issue.

TREATMENT PROTOCOLS & DILEMMAS

As Dr. Spires notes, treating sepsis has not been an exact science. But, as with detection, treatment in recent years has progressively become more standardized.

Standard therapies include antibiotics—typically broad-spectrum versions that work against several of the more common bacteria—administered intravenously to work more quickly. Additional IV fluids can mitigate shock by keeping blood pressure from plummeting. Medications typically

Continued on page 54

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Continued from page 52

include corticosteroids to reduce systemic inflammation and vasopressors to boost blood pressure. Various equipment can also factor into treatment, including mechanical ventilation and kidney dialysis, among others.

But widespread antibiotic stewardship initiatives can sometimes clash with rapid sepsis treatment, Dr. Spires says.

"Trying to put these patients in a box and check off these items can have other downstream consequences, such as increased inappropriate broad-spectrum antibiotic use," he explains. "If you're someone who's overly worried about meeting sepsis criteria, then you're more likely to give someone antibiotics who doesn't necessarily need them, just in case that patient does have an infection. Consequently, that can cause some harm as well."

Still, the efforts surrounding standardized care have generally paid off in spades, with improved survival rates, Dr. Spires notes. "The critical care aspect of treating sepsis is largely why patients do better than they used to," he says. "We end up causing patients less harm and have reduced hospital-acquired infections, so more patients improve."

STRATEGIC TRANSITION APPROACHES

Even with the array of protocols now in place to streamline sepsis diagnosis and therapy, effectively transitioning patient care from unit to unit and hospital to home remains a particular challenge, experts say.

"Sepsis is not just a hospital condition," Dr. Guy explains. "Even when you survive the initial illness, a typical sepsis patient accesses healthcare for a year afterward at a rate greater than if they'd not had sepsis. They're more prone to additional infections and go to the ER more frequently afterward. It leaves them drained."

Here are some guidelines to minimize the effects:

- **Enact additional protocols** to monitor sepsis patients as they enter step-down units or rehabilitation facilities, or after discharge. Bush says this should include educating

THE PUZZLING LINK BETWEEN SEPSIS & COVID-19

What's the difference between sepsis and the inflammatory cascade known as a "cytokine storm" that can be a severe complication of COVID-19? Clinicians don't yet know.

This uncertainty underscores how quickly science is attempting to catch up with revelations surrounding the novel coronavirus as it claims hundreds of thousands of lives across the globe. "That's the crux of the matter," says Dr. Spires. "This virus is causing huge amounts of cytokine storm, and it's impossible to tell the difference."

As with most infections, COVID-19 causes mild to moderate symptoms in most patients. But 5% to 10% of patients require ICU admission and mechanical ventilation, says **Kym Smith**, RN, CDS, Clinical Director within HealthTrust Clinical Services. While not all patients with severe COVID-19 will develop sepsis, those who develop acute respiratory distress syndrome (ARDS) or pneumonia stand a higher chance of sepsis, she notes.

"Patients with sepsis eventually will land in the ICU, whether they're admitted right away or not," she explains. "Patients are going to need vasopressor drips that help boost blood pressure, and that can only be done in the ICU. It's not a huge population, but it's happening."

Given the resemblance between sepsis and the systemic inflammatory response that can characterize some severe COVID-19 cases, treatment approaches can also be similar, Dr. Spires says.

"If you think the systemic inflammatory response is because of an infection, that's sepsis," he explains. "For severe sepsis patients, even when it's from COVID-19, I don't think it's wrong to give them antibiotics if there's a possible secondary bacterial infection. You can always back off the antibiotics in a few days if you get evidence it's not [bacterial in nature]."

Dr. Spires and Smith agree that HealthTrust members will need to be nimble as the pandemic continues to effectively treat COVID-19 patients presenting with sepsis or similar symptoms. "With COVID, there's no magic cure," Smith says. "It's just supportive care. And that's basically what you're doing with sepsis. We don't have any magic antibiotic or anti-viral medication at this point—you're supporting what's going on as it unfolds."

patients and caregivers about issues such as following up with primary care physicians and understanding worrisome symptoms. "These are complicated patients," she explains, "and sometimes their different comorbid conditions hinder their transition."

- **Manage patients' antibiotic treatment**. This is often not tracked accurately or effectively, Dr. Spires says. "We know from a study our group did a year ago that 40% of antibiotic utilization related to the hospitalization is after the hospital stay," he explains. "That transition from hospital to long-term care facility or to the home is a huge risk for someone getting too much of an antibiotic."
- **Engage multidisciplinary efforts**. A patient's care should be coordinated among clinicians and pharmacists. This requires resource dedication from hospital leadership to address the issue, Dr. Spires says. "It ultimately benefits the hospital."
- **Track outcomes**. CMS sepsis quality requirements provide a built-in reason to track outcomes well: The resulting data is publicly reported. Technology advances such as artificial intelligence promote these efforts, along with clinical analytics.

"The biggest thing is for us to understand how much antibiotics are given outside the hospital, long-term care or other facilities," Dr. Spires says. "Then, we can impact that metric."

Electronic medical records generally collect sepsis-related data and help trigger responses, as well as track the outcomes, Bush notes. "Then, it's the detailed task of going back and examining the outcomes," she says, "and getting data back to the right people so they can react appropriately." **HT**

FOR ASSISTANCE in reducing complications such as sepsis, consider HealthTrust Clinical Data Solutions Care Redesign services. Contact Kimberly Wright, RN, AVP, Clinical Data Solutions, at kimberly.wright@healthtrustpg.com for additional information.

A web of WEAK SPOTS

Cyberattacks during COVID-19 highlight a pressing need for cybersecurity

DURING THE COVID-19 PANDEMIC, hospitals have taken heroic efforts to protect their patients and staff from the disease. But there is another invisible threat the virus is posing in the form of cyberattacks. Malicious acts, including phishing campaigns and ransomware, may not only compromise hospital information systems and data, but, because so many medical devices are connected to computer networks, they can also put patients in direct danger.

"A public health emergency brings out the best in some people and the worst in cybercriminals," says **Terry Moon**, AVP of IT and Cybersecurity at HealthTrust. "Their scam emails and websites are capitalizing on the anxiety and urgency around the coronavirus in hopes that you'll click first and ask questions later."

A GLOBAL THREAT

The rise in cyberattacks has led to warnings from the FBI and the U.S. Department of Homeland Security about malware targeting supply chains, as well as hackers stealing data from medical centers and universities researching COVID-19.

The impact is being felt around the world, says **Kent Petty**, HealthTrust Chief Information Officer. "A hospital in the Czech Republic, a Paris hospital system, the computer systems of Spain's hospitals, hospitals in Thailand, medical clinics in Texas, a healthcare agency in Illinois—all have reported attacks," Petty notes.

Europe's largest private hospital operator, Fresenius, is a major provider of the dialysis products and services that are in high demand throughout the world due to COVID-19. It experienced a ransomware cyberattack on its technology systems in May. The attack affected every part of the enormous company's global operations, which holds nearly 40% of the U.S. dialysis market. The World Health Organization (WHO) has reported a five-fold number of cyberattacks, Petty explains,

The uncertainty and panic around COVID-19 creates a perfect storm for hackers because end users are more vulnerable to phishing attacks.

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adding: "It is a safe assumption that many more attacks have not been reported."

VIRUS VULNERABILITIES

The uncertainty and panic around COVID-19 create a perfect storm for hackers because their most valuable tools—end users—are more vulnerable to phishing attacks. "People are anxious for news and updates around COVID-19," says Petty. "They're doing more online, looking for how to get PPE [personal protective equipment], and doing more on social media—all of which makes them more susceptible to scams."

With healthcare organizations incredibly stressed and overworked, it means they are more likely to accede to demands for ransom to reclaim their systems. This is another reason cybercriminals are targeting the industry.

"Situations like pandemics create makeshift smoke screens, so hackers can come in through a back door to perform nefarious acts," Moon explains. "In addition, opportunities created by the need for PPE and related items cause a panic that allows hackers to broaden their attack vectors with creative ideas to gain access to the hospital systems."

The type of attacks vary. "We've seen phishing emails purporting to be from real retailers about PPE for sale and from individuals saying that they have a stash of PPE they'd offer up at the right price," explains Moon. Many are customized for the company or person, making them appear legitimate. And there has been an increase in identity-fraud attacks as hackers target stimulus checks and employment benefits, Petty adds. Hackers also search for infrastructure weaknesses, such as organizations that don't use multifactor authentication.

The explosion in people working from home opens another potential vulnerability for hospitals if home users are compromised, says Petty. Hackers use the virtual private network (VPN) as a conduit into the health system. Such actions have triggered a warning from Homeland Security.

Hackers may also use email, remote access accounts, or business-to-business connections of smaller, less secure vendors as a way to get at bigger targets, Petty explains.

PROTECTING DEVICES

Of particular concern are medical devices, Petty notes. "While we haven't yet seen attacks specifically targeting medical devices, the criminals aim for the most-critical systems to maximize their leverage to get paid or the value of the information they steal. In healthcare, those critical systems include many medical devices."

While continued due diligence and process education will always be paramount to reducing or eliminating these threats, Moon explains, the good news is that the Food and Drug Administration (FDA) and hospitals have made substantial progress in creating in-depth defense systems to reduce the potential impact of device hacking.

It isn't easy to ensure that connected devices are protected in a hospital system because of the number of devices, the size and architecture of the network environment, and the management of asset inventory, Moon explains. Many electronic systems and discovery tools need to be implemented to identify threats, manage inventories and control the flow of traffic. Here are some best practices to consider:

- Have a documented, verified and repeatable recovery plan in place that is tested routinely.
- Include aspects of real/near-time backups of critical systems (isolation from the rest of the network for protection).

Continued on page 60

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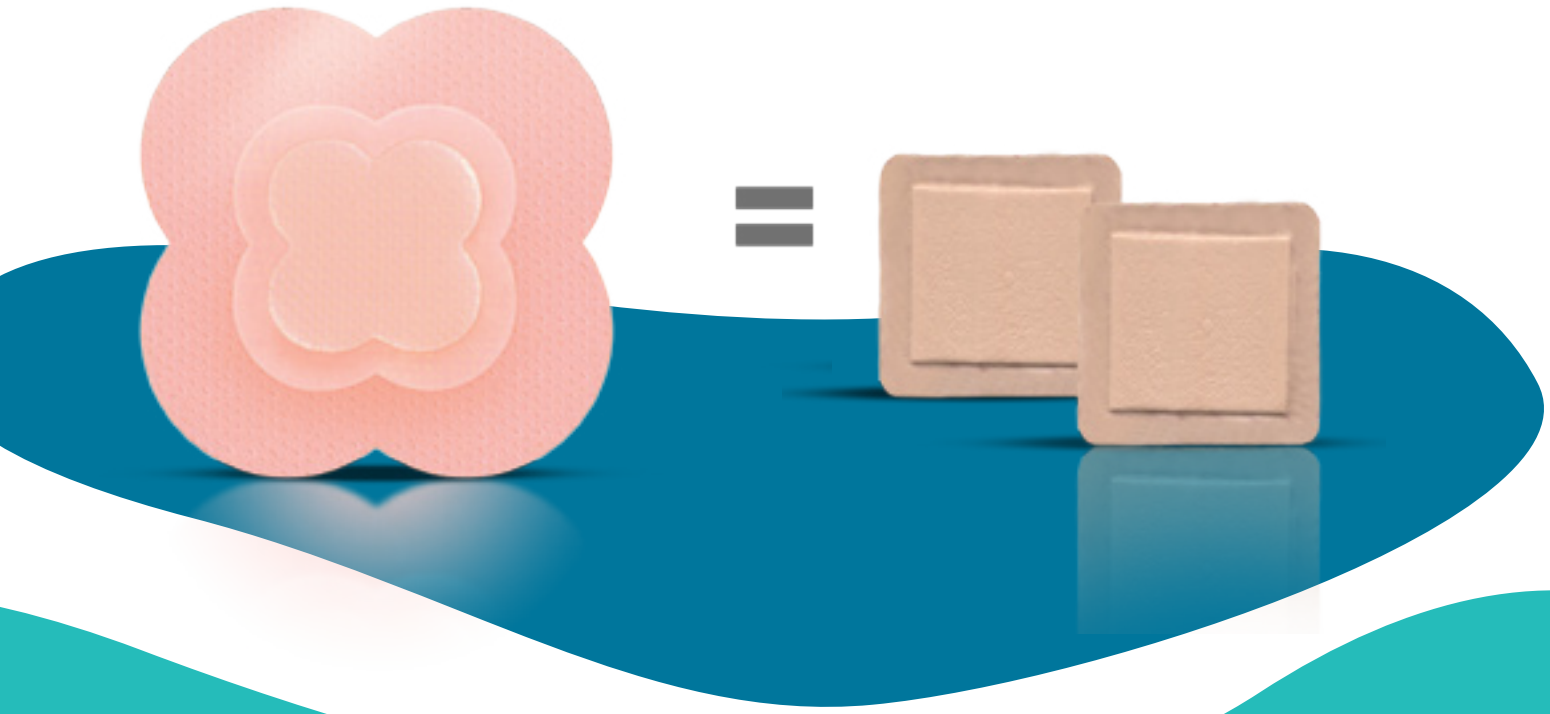

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References: 1. Joy H et al. A collaborative project to enhance efficiency through dressing change practice. Journal of Wound Care. Vol 24. No 7. July 2015 P3-4. 2. Data on File Report GMCA-DOF/08 –April 2016, A. Rossington. Product Performance of Next Generation ALLEVYN LIFE.

Continued from page 58

- Provide continuous education to end users and other teams to ensure that when a security incident or disaster occurs, all hands are on deck with a full understanding of their responsibilities.

"Having all of this in place before an event occurs will reduce the impact to HealthTrust member organizations and the patients under their care," Moon explains.

It's also important that hospital systems ensure the devices they acquire have proper security controls and are identified in an asset management database. Then, if there is a vulnerability or compromise, the infected devices can be quickly located and patched or isolated from the network. "Organizations should also utilize network segmentation to isolate vulnerable medical devices from the rest of the network," adds Petty.

SETTING SECURITY STANDARDS

At the hospital level, it's best practice for IT professionals to have a complete inventory of assets and follow good tracking system hygiene like configuration, patching, updates, retiring out-of-date systems and endpoint protection, Petty explains. He advises that they also search for open protocols/systems that could be compromised to allow remote access, as well as require multifactor authentication on remote access.

Moon notes that it's also important to consider suppliers and how they could make systems vulnerable. "[Think about]: What data do they have, and is it protected? What access to your systems/network do they have, is it necessary and is it secure?" Moon suggests.

At the end-user level, security starts with the basics, such as strong passwords. "The longer, the better," Moon adds. Also, employees can be trained on how to recognize phishing emails that can compromise the system (see sidebar below). Here are some general tips:

- **Don't click.** Many phishing emails ask you to open an attachment or click a link. Don't do it. Instead, confirm any information on the coronavirus from reliable sources like the WHO website.
- **Guard your information.** Watch for emails asking for personal information such as birthdate, payment details, Social Security number or other sensitive patient data. They are likely to be fraudulent.
- **Be on the lookout for typos.** Grammatical errors or misspelled words are classic signs of phishing.
- **Know the sender.** Be suspicious of any email from an unknown address.
- **Take your time.** A deadline or sense of urgency almost always indicates a form of phishing attack. "The bad guys want to make you feel flustered and panicked by telling you that you only have a certain amount of time to take action, or bad things will happen," Moon explains. "Don't panic. Take the time to stop and think."

"Information security teams go to great lengths to put mitigations in place that help slow the impact of hacking, including alerts to let them know when something happens," Moon adds. "They may be the first people to contact you letting you know your workstation has been compromised." **HT**

WARNING SIGNS TO WATCH FOR

Petty and Moon provide some signs of cybercriminal activity you may find in your email inbox.

- Emails from a well-known health plan provider (even the same one your company uses), thanking you for enrolling in their "Coronavirus Coverage." The email may include a link for the participant to make a payment for the coverage. Do not click on the link.
- Emails that appear to come from your company's IT department, offering links on new ways to connect, or a faster VPN. Before you click, confirm with IT that the email is from your company.
- Emails that claim to come from the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO) and encourage you to click on a link for information. Instead, go directly to these organizations' websites.
- Emails from doctors or other health groups offering links to "safety measures" to take during the pandemic or to maps of local infections.
- Emails offering COVID-19 vaccinations. If there's been a medical breakthrough, you likely won't hear about it via email.

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Please see accompanying Highlights of full Prescribing Information for additional important information.

- Thrombosis may occur with immune globulin intravenous (IGIV) products, including Octagam® 10%. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.
- Renal dysfunction, acute renal failure, osmotic nephropathy, and death may occur with the administration of Immune Globulin Intravenous (Human) (IGIV) products in predisposed patients. Renal dysfunction and acute renal failure occur more commonly in patients receiving IGIV products containing sucrose. Octagam 10% does not contain sucrose.
- For patients at risk of thrombosis, renal dysfunction or renal failure, administer Octagam 10% at the minimum infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Important Safety Information

Octagam® 10% is contraindicated in patients who have a history of severe systemic hypersensitivity reactions, such as anaphylaxis, to human immunoglobulin. Octagam 10% contains trace amounts of IgA (average 106 µg/mL in a 10% solution). It is contraindicated in IgA-deficient patients with antibodies against IgA and history of hypersensitivity. The most serious drug-related adverse event reported with Octagam 10% treatment was a headache (0.9% of subjects). The most common drug-related adverse reactions reported in >5% of the subjects during a clinical trial were headache, fever, and increased heart rate.

Please see accompanying Highlights of full Prescribing Information for additional important information.

HealthTrust Contract #4861

Date of preparation: 5/2020. GAM10-0201- PAD

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HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use OCTAGAM 10% safely and effectively. See full prescribing information for OCTAGAM 10%.

OCTAGAM 10% [Immune Globulin Intravenous (Human)]
liquid solution for intravenous administration
Initial U.S. Approval: 2014

WARNING
THROMBOSIS, RENAL DYSFUNCTION AND ACUTE RENAL FAILURE
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- Thrombosis may occur with immune globulin intravenous (IGIV) products, including OCTAGAM 10%. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.
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----------INDICATIONS AND USAGE ----------

- OCTAGAM 10% is an immune globulin intravenous (human) liquid preparation indicated for the treatment of chronic immune thrombocytopenic purpura (ITP) in adults.

---------- DOSAGE AND ADMINISTRATION ----------

For intravenous use only.

Indication	Dose	Initial Infusion rate	Maintenance Infusion Rate (if tolerated)
Chronic ITP	1 g/kg daily for 2 consecutive days	1.0 mg/kg/min (0.01 mL/kg/min)	Up to 12.0 mg/kg/min (Up to 0.12 mL/kg/min)

- Ensure that patients with pre-existing renal insufficiency are not volume depleted; discontinue OCTAGAM 10% if renal function deteriorates.
- For patients at risk of renal dysfunction or thrombotic events, administer OCTAGAM 10% at the minimum infusion rate practicable.

----------DOSAGE FORMS AND STRENGTHS----------

Solution containing 10% IgG (100 mg/mL)

---------- CONTRAINDICATIONS----------

- History of anaphylactic or severe systemic reactions to human immunoglobulin
- IgA deficient patients with antibodies against IgA and a history of hypersensitivity

----------WARNINGS AND PRECAUTIONS ----------

- IgA-deficient patients with antibodies against IgA are at greater risk of developing severe hypersensitivity and anaphylactic reactions to OCTAGAM 10%. Epinephrine should be available immediately to treat any severe acute hypersensitivity reactions.
- Monitor renal function, including blood urea nitrogen and serum creatinine, and urine output in patients at risk of developing acute renal failure.
- Falsely elevated blood glucose readings may occur during and after the infusion of OCTAGAM 10% with testing by some glucometers and test strip systems.
- Hyperproteinemia, increased serum osmolarity and hyponatremia may occur in patients receiving OCTAGAM 10%.
- Hemolysis that is either intravascular or due to enhanced red blood cell sequestration can develop subsequent to OCTAGAM 10% treatments. Risk factors for hemolysis include high doses and non-O-blood group. Closely monitor patients for hemolysis and hemolytic anemia.
- Aseptic Meningitis Syndrome may occur in patients receiving OCTAGAM 10%, especially with high doses or rapid infusion.
- Monitor patients for pulmonary adverse reactions (transfusion-related acute lung injury (TRALI)).
- OCTAGAM 10% is made from human plasma and may contain infectious agents, e.g. viruses and, theoretically, the Creutzfeldt-Jakob disease agent.

---------- ADVERSE REACTIONS----------

The most common adverse reactions reported in greater than 5% of subjects during a clinical trial were headache, fever and increased heart rate.
To report SUSPECTED ADVERSE REACTIONS, contact Octapharma at 1-866-766-4860 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch*.

----------DRUG INTERACTIONS----------

The passive transfer of antibodies may:
Confound the results of serological testing.
Interfere with the immune response to live viral vaccines, such as measles, mumps, and rubella.

---------- USE IN SPECIFIC POPULATIONS----------

- Pregnancy: no human or animal data. Use only if clearly needed.
- Geriatric Use: In patients over age 65 or in any person at risk of developing renal insufficiency, do not exceed the recommended dose, and infuse OCTAGAM 10% at the minimum infusion rate practicable.

Revised: **August 2018**

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STRAIGHT TALK: communicating during a crisis

How healthcare systems can fine-tune their strategies during COVID-19 & beyond

COMMUNICATING DURING A GLOBAL PANDEMIC requires informing many groups—employees, the media, the public and even the authorities—about topics that are sensitive, constantly evolving and perhaps even scary. And doing it fast. Health systems across the nation discovered the often-difficult and complicated nature of this effort firsthand as they enacted communications strategies during COVID-19.

When coronavirus broke, the uncertainty surrounding it, the severity of its nature, the speed of its spread and the lack of resources to fight it put healthcare organizations in crisis mode.

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They required a deft communications strategy—one that had to be flexible yet consistent, each day. Add to the quagmire, complications around disclosing accurate information while keeping people calm during a crisis and protecting patients' privacy.

KNOW WHAT TO SHARE

Those representing hospital systems and speaking to the media must be trained on what can and cannot be said about patients' health in compliance with the Health Insurance Portability and Accountability Act (HIPAA), while still keeping the public adequately informed about the status of the disease in their communities and maintaining its trust.

According to the Advisory Board, here are just some of the types of information health systems should focus on when establishing a communications plan during a crisis:

- Establish a place for FAQs about the coronavirus on your website.
- Provide clear guidance to patients about when, where and how they should seek care, including through online symptom checkers, video visits or in-person visits.
- Give clear information about changes to visitation policies, elective surgeries and more.
- Describe how your facility is responding to the need for space, supplies and the response to the infection control department.
- Address the questions that are most worrisome to the public, even when you don't know the answer. Communicate what you do know, and provide the best information available at the time.

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PRIVACY DURING A PANDEMIC

During the COVID-19 pandemic, providers strike a fine balance between protecting patient privacy and keeping the community informed. Healthcare systems have had to navigate uncharted waters when it comes to communications and adhering to privacy regulations while also sharing relevant patient data.

The U.S. Department of Health and Human Services Office for Civil Rights (HHS OCR) allows healthcare systems to share the name of an individual who has been infected with or exposed to COVID-19 with law enforcement, paramedics, first responders and public health authorities without the individual's authorization under certain circumstances, such as disclosure being required for treatment or when first responders are at risk of infection.

When HealthTrust member facility Scripps Health learned they had a patient test positive for COVID-19 on March 9, they agreed to reveal their hospital's name publicly, but waited until the hospital's employees knew, as many people would need to enter quarantine.

Other hospitals across the country have faced similar challenges, forcing them to think more intently about privacy-related issues than they did in the past. How much information should a hospital

KNOW HOW TO SHARE IT

In order to communicate these important factors facing your patient population, the Advisory Board recommends the following:

- Use many different channels, including emails, websites, patient portals and social media channels.
- Provide staff with up-to-date information and talking points on policies and procedures, so the messages are consistent.
- Prepare responses and content for worst-cast scenarios, to help facilitate swift responses when time is of the essence. **HT**

FOR MORE INFORMATION on communication best practices, visit the Advisory Board at **bit.ly/AdvisoryBoardCommunications**

release about its cases, and how? Are HIPAA (Health Insurance Portability and Accountability Act) laws being abided by when patient data is shared?

HealthTrust Physician Advisor **Pete Brookmeyer**, M.D., an infectious disease specialist with Centura Health in Colorado Springs, Colorado, believes it's reasonable for hospitals to share certain COVID-19 data, such as the total number of cases and policies that are being rolled out. The key is weighing the benefit of educating the public against the drawback of potentially inciting fear.

"The issue with releasing information is—do you make everybody panic in the community?" he says. "That's a fine line to walk."

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Product Costs for Factor Concentrates in von Willebrand Disease (VWD) May Be Substantial

Converting to a von Willebrand factor/factor VIII concentrate (VWF/FVIII) that requires a **lower dose** may **potentially reduce** total product costs

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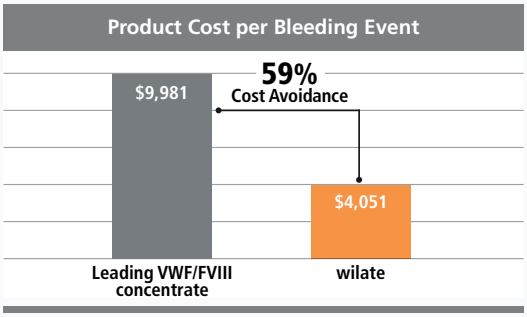
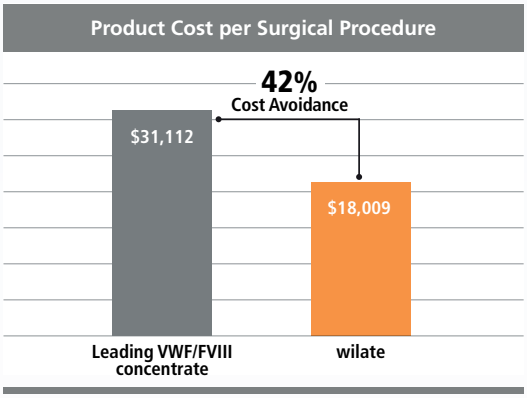
Differences in product usage can have health economics consequences. Based on the above data, total product costs for wilate would potentially be 59% lower for on-demand treatment and 42% lower for perioperative management of bleeding.[1,7†‡]

Product Cost for On-demand Treatment and Perioperative Management of Bleeding[1,7†‡]





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Please see accompanying Highlights of Prescribing Information for additional important information.

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Convert to wilate to Potentially Reduce Your Total Product Costs

Explore the potential savings for your institution with the **NEW** wilate cost reduction calculator at **connect.octapharmausa.com/calculator**

*Results and dosing assumptions are from different clinical trials with differing clinical characteristics and study parameters. Use caution when comparing results from different clinical trials. There are no head-to-head clinical trials comparing the efficacy of wilate versus other VWF/FVIII concentrates. †Pricing based on VWF:RCo. Average sale price (ASP) is a sale price that may not reflect actual price paid by an individual purchaser after any discounts. ASP is defined by CMS as a manufacturer's sales of a drug to all purchasers in the United States in a calendar quarter divided by the total number of units of the drug sold by the manufacturer in that same quarter. ‡Lower cost refers only to cost of product administered and does not refer to any other costs associated with treatment of VWD, such as costs related to adverse events, drug administration, or hospitalization. Costs refer only to the cost of product administered and are based on published ASP. §Based on the Recommended Dosing Guide for wilate in VWD patients. See Dosage and Administration, section 2.1 of wilate full Prescribing Information.

Important Safety Information

wilate is contraindicated in patients with known hypersensitivity reactions, including anaphylactic or severe systemic reactions, to human plasma-derived products, any ingredient in the formulation, or components of the container. Anaphylaxis and severe hypersensitivity reactions are possible. Thromboembolic events may occur. Monitor plasma levels of FVIII activity. The most common adverse reactions (≥1%) in patients with VWD were hypersensitivity reactions, urticaria, and dizziness. The most serious adverse reactions in patients with VWD were hypersensitivity reactions.

Please see accompanying Highlights of Prescribing Information for additional important information.

References: 1. Collins CE. Supplement to JCOM. March/April 2019. **2.** wilate® full Prescribing Information. Paramus, NJ; rev 2019. **3.** Berntorp E, et al. Haemophilia. 2009;15:122-130. **4.** Lillicrap D, et al. Thromb Haemost. 2002;87:224-230. **5.** Srivastava A, et al. Haemophilia. 2017;23:264-272. **6.** Thompson AR, et al. Haemophilia. 2004;10:42-51. **7.** CMS Medicare Part B ASP data accessed on March 18, 2020.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use WILATE safely and effectively. See full prescribing information for WILATE.

WILATE, von Willebrand Factor/Coagulation Factor VIII Complex (Human)
Lyophilized Powder for Solution for Intravenous Injection
Initial U.S. Approval: 2009

---------- **RECENT MAJOR CHANGES** ----------

Indications and Usage (1)	09/2019
Dosage and Administration (2.1)	09/2019
Warnings and Precautions (5)	09/2019

---------- **INDICATIONS AND USAGE** ----------

WILATE is indicated in children and adults with von Willebrand disease for:

- On-demand treatment and control of bleeding episodes
- Perioperative management of bleeding

WILATE is indicated in adolescents and adults with hemophilia A for:

- Routine prophylaxis to reduce the frequency of bleeding episodes
- On-demand treatment and control of bleeding episodes (1)

---------- **DOSAGE AND ADMINISTRATION** ----------

For Intravenous Use Only

VWD

- Use the following formula to determine required dosage (2.1): Required IU = body weight (BW) in kg x desired VWF:RCo rise (%) (IU/dL) x 0.5 (IU/kg per IU/dL)
- Adjust dosage and duration of the substitution therapy depending on the severity of the VWD, on the location and extent of the bleeding, and on the patient's clinical condition (2.1)
- Dosing recommendations (2.1)

Type of Hemorrhages/ Surgery	Loading Dosage (IU VWF:RCo/ kg BW)	Maintenance Dosage (IU VWF:RCo/ kg BW)	Therapeutic Goal
Minor Hemorrhages	20-40 IU/kg	20-30 IU/kg every 12-24 hours	VWF:RCo and FVIII activity trough levels of >30%
Major Hemorrhages	40-60 IU/kg	20-40 IU/kg every 12-24 hours	VWF:RCo and FVIII activity trough levels of >50%
Minor Surgeries (including tooth extraction)	30-60 IU/kg	15-30 IU/kg or half the loading dose every 12-24 hours for up to 3 days	VWF:RCo peak level of 50% after loading dose and trough levels of > 30% during maintenance doses
Major Surgeries	40-60 IU/kg	20-40 IU/kg half the loading dose every 12-24 hours for up to 6 days or more	VWF:RCo peak level of 100% after loading dose and trough levels of >50% during maintenance doses

In order to decrease the risk of perioperative thrombosis, FVIII activity levels should not exceed 250%.

Hemophilia A

- One International Unit (IU) of factor VIII (FVIII) activity per kg body weight increases the circulating FVIII level by approximately 2 IU/dL (1.7 IU/dL for adolescents and 2.3 IU/dL for adults)
- Use the following formula to determine required dosage (2.1): Required IU = body weight (BW) in kg x desired Factor VIII rise (%) (IU/dL) x 0.5 (IU/kg per IU/dL)
- Dosing for routine prophylaxis (2.1):

Patients	Dose (IU/kg)	Frequency of infusions
Adolescents and adults	20-40 IU/kg	Every 2 to 3 days

- Individualize dosage based on the patient's weight, type and severity of hemorrhage, FVIII level, presence of inhibitors and the patient's clinical condition (2.1).

---------- **DOSAGE FORMS AND STRENGTHS** ----------

WILATE is available as a sterile, lyophilized powder for reconstitution for intravenous injection, provided in the following nominal strengths per single-use vial (3):

- 500 IU VWF:RCo and 500 IU FVIII activities in 5 mL
- 1000 IU VWF:RCo and 1000 IU FVIII activities in 10 mL

---------- **CONTRADICTIONS** ----------

Do not use in patients with known hypersensitivity reactions, including anaphylactic or severe systemic reaction, to human plasma-derived products, any ingredient in the formulation, or components of the container (4)

---------- **WARNINGS AND PRECAUTIONS** ----------

- Anaphylaxis and severe hypersensitivity reactions are possible (5.1).
- Thromboembolic events may occur. Monitor plasma levels of FVIII activity (5.2).
- Development of neutralizing antibodies to FVIII and to VWF, especially in VWD type 3 patients, may occur (5.3).
- WILATE is made from human plasma and carries the risk of transmitting infectious agents (5.4).

---------- **ADVERSE REACTIONS** ----------

The most common adverse reactions (≥ 1%) in clinical studies on VWD were hypersensitivity reactions, urticaria, and dizziness (6.1)

The most common adverse reaction (≥ 1%) in clinical studies in hemophilia A was pyrexia (fever) (6.1).

---------- **USE IN SPECIFIC POPULATIONS** ----------

Pregnancy: no human or animal data. Use only if clearly needed.

Lactation: There is no information regarding the presence of WILATE in human milk, the effect on the breastfed infant, and the effects on milk production.

Pediatric Use: No dose adjustment is needed for pediatric patients as administered dosages were similar to those used in the adult population.

Geriatric Use: Although some of the subjects who participated in the WILATE studies were over 65 years of age, the number of subjects was inadequate to allow subgroup analysis to support recommendations in the geriatric population.

---------- **PATIENT COUNSELING INFORMATION** ----------

- Advise the patients to read the FDA-approved patient labeling (Patient Information and Instructions for Use).
- Inform patients of the early signs of hypersensitivity reactions including hives, generalized urticaria, tightness of the chest, wheezing, hypotension, and anaphylaxis. If allergic symptoms occur, advise patients to discontinue the administration immediately and contact their physician to administer appropriate emergency treatment.
- Inform patients that undergoing multiple treatments with WILATE may increase the risk of thrombotic events thereby requiring frequent monitoring of plasma VWF:RCo and FVIII activities.
- Inform patients that there is a potential of developing inhibitors to VWF, leading to an inadequate clinical response. Thus, if the expected VWF activity plasma levels are not attained, or if bleeding is not controlled with an adequate dose or repeated dosing, contact the treating physician.
- Inform patients that despite procedures for screening donors and plasma as well as those for inactivation or removal of infectious agents, the possibility of transmitting infective agents with plasma-derived products cannot be totally excluded.

To report SUSPECTED ADVERSE REACTIONS, contact Octapharma USA Inc. at 1-866-766-4860 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Revised: November 2019

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Date of preparation: 6/2020. WIL-0257-PAD

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In this together

Companies step up to give back to those on the pandemic's frontlines

FROM GLOBAL GIANTS TO LOCAL MOM-AND-POP SHOPS, businesses have rallied around the healthcare industry to support the ones working hard and making sacrifices to care for patients and communities during this extraordinary time. Here are just a few of those stories. (See a list of sources for this article at **healthtrustpg.com/InThisTogether**.)

FORD PIVOTS TO CREATE FACE SHIELDS, GOWNS & VENTILATORS

Ford Motor Company has a strong reputation for world-class corporate social responsibility. The Detroit-based automaker nimbly used its vast manufacturing resources to produce critically needed personal protective equipment (PPE) for healthcare workers and ventilators for patients, among other efforts.

Ford worked with Beaumont Health in Detroit to design and produce urgently needed reusable medical gowns for healthcare workers. The gowns, made from the material used in Ford vehicle airbags, can be washed up to 50 times.

According to Ford's media releases, in collaboration with healthcare companies and government agencies, by May, Ford had helped produce more than 8 million face shields; 100,000 respirators; about 1 million face masks per day; and 100,000 isolation gowns per week. It was projecting to make 50,000 ventilators and 1.3 million gowns by July. Ford is helping commercial healthcare companies increase production of their PPE and medical devices as well.

Ford Motor Company

HealthTrust reached out to Ford upon hearing of its plans and provided contact information for its member hospitals in the areas identified by the Federal Emergency Management Agency (FEMA).

"This is a great example of American ingenuity that was prompted out of compassion for first responders, caregivers and patients," says **Ed Jones**, President and CEO of HealthTrust. "We are grateful to Ford and appreciate the collaboration to ensure our members are among the first to receive this generous help at a time of critical need."

"At Ford, we feel a deep obligation to step up and contribute in times of need," says **Ken Musgrave**, Global Director, D-Ford at Ford Motor Company. "Within two weeks, we went from prototyping to producing 1 million face shields. We acted fast and with conviction, and the response from people across the country that are receiving this lifesaving equipment is incredibly humbling."

INNOVATION THAT'S OUT OF THIS WORLD

If NASA can put a man on the moon, just imagine what the space giant can do for the healthcare industry. The organization joined with a task force in California to help construct medical devices for patients with COVID-19. NASA's Armstrong Flight Research Center partnered with Antelope Valley Hospital, the City of Lancaster and other organizations to come up with new solutions for medical equipment shortages, according to NASA.gov.

The task force is working with Antelope Valley Hospital to provide alternative solutions to equipment that is not available for a large-scale emergency. One of the first wins was the creation of a new oxygen hood for doctors, which was quickly put into production.

"NASA is more than scientists, engineers and explorers. We are neighbors and members of communities across the country," says NASA Administrator **Jim Bridenstine**, according to the organization's website. "In a time like this, it's critical that we contribute the vast expertise of our workforce to do all we can to help our neighbors, our communities and the nation."

The oxygen hood is just one of many examples of ingenuity that have come out of NASA during the pandemic. Engineers at NASA's Jet Propulsion Laboratory designed a new high-pressure ventilator called VITAL (Ventilator Intervention Technology Accessible Locally) that is tailored to treat coronavirus patients. The ventilator was invented to free up traditional ventilators for the most-severe COVID-19 patients. The prototype was quickly approved by the Food and Drug Administration (FDA) for emergency use.

MORE STORIES OF CORPORATE COLLABORATION

Home Depot donates masks and materials for isolation gowns

According to members' social media pages, The Home Depot in Horn Lake, Mississippi, donated all available protective-grade plastic sheeting to Methodist Olive Branch Hospital for the production of PPE. Employees from across the hospital produced up to 250 isolation gowns per day. The Home Depot in Locust Grove, Georgia, donated 10,000 N-95 masks to the healthcare professionals at RWJBarnabas Health in New Jersey.

Lowe's provides 19,000 masks to CHRISTUS Health

Lowe's Home Improvement stepped up to help hospitals by donating $10 million in PPE, according to its social media accounts. In April, employees from Lowe's

It may not be rocket science, but NASA's special brand of innovation couldn't come to healthcare at a better time, as lifesaving medical equipment and supplies have been in critical demand. **HT**

NASA/JPL-Caltech

Some of the dozens of engineers involved in creating a ventilator prototype specially targeted to coronavirus disease patients at NASA's Jet Propulsion Laboratory in Southern California.

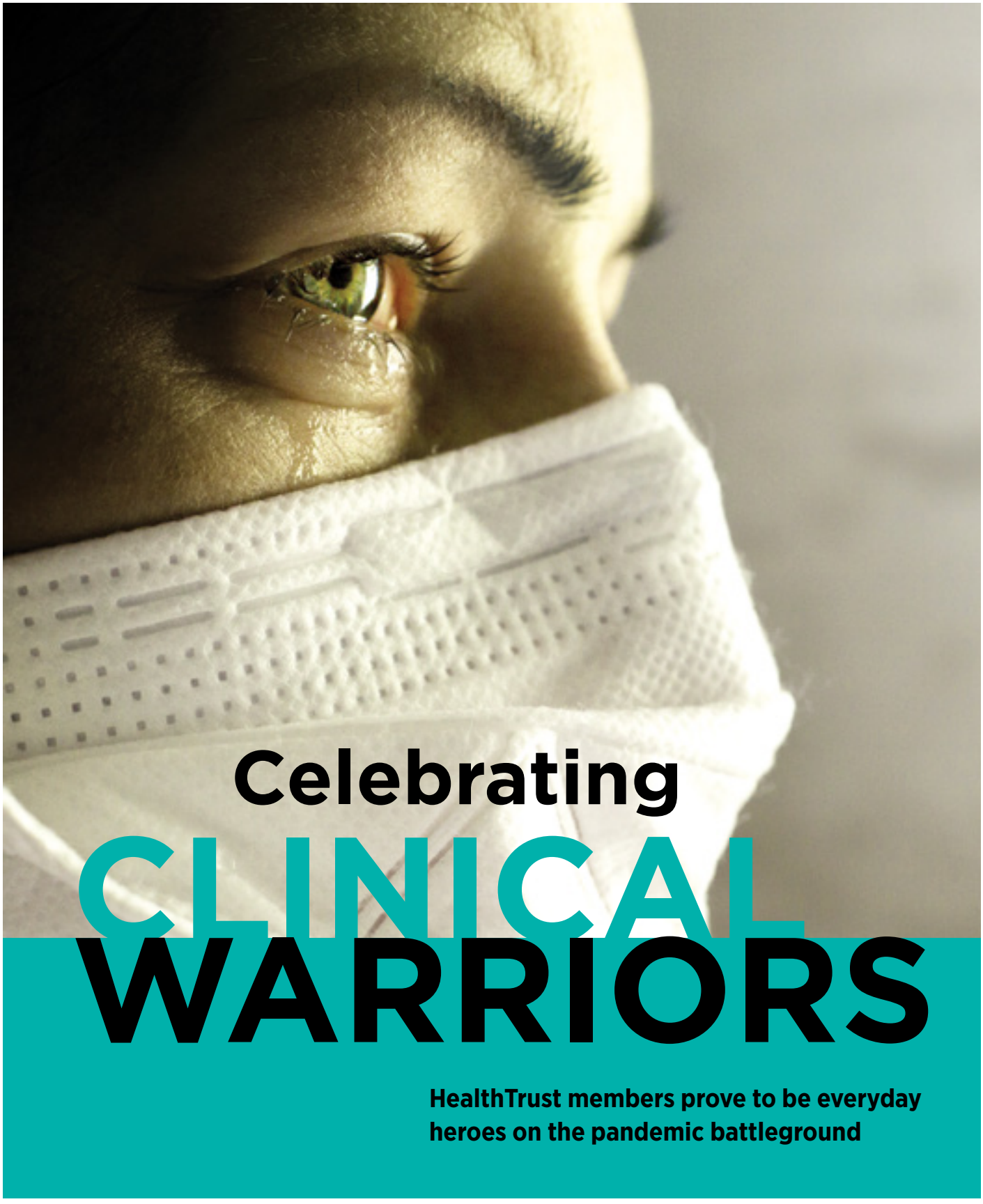
dropped off 19,000 masks to the corporate offices of CHRISTUS Health in the Southwest.

John Hancock feeds Boston hospital employees
According to PR Newswire, the Boston financial services firm John Hancock partnered with the nonprofit Off Their Plate to provide more than 8,500 meals to the essential workforce, including Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Massachusetts General Hospital and Tufts Medical Center.

Southeastern Grocers covers grocery bills
As reported in the *Tampa Bay Times*, on April 13, the parent company of Winn-Dixie and other food stores in the Southeast waved the grocery bills for those shopping at all 29 of its stores throughout seven states during a special shopping hour held especially for front-line workers.

Plastic Fabricators sources high-demand materials for plastic shields
The plastic maker in York, Pennsylvania, helped WellSpan Health construct its drive-through testing site at the county fairgrounds, according to the Lebanon Daily News website. CEO Bill Frantz worked with a major supplier to obtain clear polycarbonate for 58 shields to prevent exposure to COVID-19.

For more stories like these about how companies are giving back to the frontlines, read the full version of this article at healthtrustpg.com/InThisTogether



Celebrating CLINICAL WARRIORS

HealthTrust members prove to be everyday heroes on the pandemic battleground

iStockphoto.com/Tomas Ragina

IN THE WAR AGAINST COVID-19, heroic front-line healthcare workers have proven themselves to be what HealthTrust is recognizing as Clinical Warriors. Their remarkable courage, sacrifice, compassion and dedication to their patients have saved lives and been an inspiration.

The stories we hear of bravery are countless, and many more of them go untold each and every day. We talked to some of these Warriors from member hospitals for the new HealthTrust podcast series, "Candid Conversations." Below we share some of their stories. Visit **https://education.healthtrustpg.com/clinical-warriors** to read more and to listen to the full interview recordings.

GOING BEYOND THE CALL OF DUTY

When hospitals in New Orleans were being overwhelmed by the pandemic, over 200 nurses in the Kansas City area stepped up to help. **Suzanne Ford**, RN, MHA, VP of Nursing Operations for HCA MidAmerica Division, says that when they put the call out for volunteers to travel to New Orleans to lend a hand, nurses signed up without hesitation. "It was an immediate, 'Yes, I will come. I will do what's needed,' " Ford recalls in an episode of the "Candid Conversations" podcast.

Nurses from Belton Regional, Overland Park Regional, Menorah Medical Center, Centerpoint Medical Center and Lee's Summit Medical Center brought much-needed relief to the staff and patients at Tulane Medical Center. The hospitals are all part of HCA MidAmerica Division.

Amelia Ellsworth, RN, CCRN, Critical Care Nurse at Centerpoint, was part of the first of three waves of nurses and joined Ford on "Candid Conversations." She says that many people have asked her why she volunteered to put herself in harm's way of the virus. "It's hard to describe that gut instinct. I think all of us in medicine, especially in critical care, are people who run toward disaster every day. This is who we are as nurses, as healthcare providers, as physicians or EMTs," she says. "We're all there to fight a fight every day."

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"Giving patients hope through a friendly face is 50% of the battle."

– Joseph Varon, M.D.

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INNOVATING NEW WEAPONS

Perhaps the strongest weapons will come in the form of treatment. Clinical Warriors at Mercy Hospital St. Louis and Albany Medical Center in New York are among those working diligently to find a treatment for COVID-19 as part of an investigation from the Food and Drug Administration (FDA), studying convalescent blood plasma therapy. Beginning in April, staff have been collecting plasma from eligible donors, administering the treatment to active patients and then reporting the results to the FDA.

Emily Schindler, M.D., Ph.D., Medical Director of Mercy Blood Donor Services in St. Louis, talked to HealthTrust about the convalescent blood plasma program and the heroic efforts of the entire hospital staff. "It's been really exceptional. The people contacted by our team are very excited to help out, rearranging their schedules to come in and donate this plasma as soon as they are eligible," says Dr. Schindler. "It's really heartwarming to see how the community has responded to this need."

FIGHTING FOR HOPE

Hope and joy have healing power—and Clinical Warriors are bringing that, too. The care team at Henrico, Parham & Retreat Doctors' Hospitals in Richmond, Virginia, surprised a patient, Freddie, with a wedding anniversary celebration that he and Peggy, his bride of 30 years, will remember for years to come. Complete with balloons, flowers and treats, Freddie and Peggy celebrated together, though separated by the hospital lobby windows.

Other healthcare workers are bringing smiles to their patients' faces by rocking the tunes. When an elderly patient at a Baylor Scott & White facility asked his nurse if she could dance, she rounded up a few team members and rose to the challenge. In a social media post shared by the hospital, a nurse said, "Seeing his big smile, him clapping along, and saying 'You precious girls, that was great!' That was the best! When people ask how we have time for this, just know, we make the time because it's totally worth it."

Some hospitals have adopted calling a "code happy" when a COVID-19 patient is being discharged. A time for celebration, healthcare workers line the halls to cheer and wave goodbye as the patient leaves the hospital.

While personal protective equipment (PPE) is necessary to protect against coronavirus, many healthcare workers believe PPE also makes it difficult to create a much-needed human connection with patients. **Joseph Varon**, M.D., Chief of Staff at United Memorial Medical Center in Houston, decided to bring back that connection by attaching a friendly photo of himself to his protective gear, encouraging other staff to follow.

"Giving patients hope through a friendly face is 50% of the battle," says Dr. Varon in an Elite Readers article.

Nurses at HCA MidAmerica hospitals are using technology to connect with patients despite having to limit the time they spend in patients' rooms because of COVID-19 restrictions. "It's anti-nurse to not be at the bedside, having that contact and sharing that compassion," says Ford. But telemedicine, texting and FaceTime are helping to bring back

that connection. "I think they have been extremely helpful … in being able to connect with the patient."

DEFENDING THE YOUNGEST AMONG US

Hospital visits can be scary for kids at the best of times, and especially so during a global pandemic. Child life specialists are there to support children and help them cope with stressful experiences.

Jessica Liles, MPS, CCLS, Director of Child Life at Le Bonheur Children's Hospital in Memphis, Tennessee, talked to HealthTrust for a "Clinical Conversations" episode. "I like to think that I'm in control, but it's things like a pandemic that help to remind me that I am not," she says. "Children are the same. They want to feel they are in control of their environment, so we help them find ways to feel they have a sense of control."

During the pandemic, Liles and her team have had to think outside the box and be creative to meet the needs of their patients. When their in-person programming was canceled, they moved many activities to the hospital's closed-circuit TV channel—including a virtual Easter egg hunt.

As the hospital prepares for the return of elective surgeries, one room has been designated specifically for COVID-19 testing, with a *Monsters, Inc.* theme to make it less scary and more familiar than a sterile testing space.

"I really think this season has caused everyone to slow down, take a step back and look at the why behind what we're doing, and figure out how we can do it even better," says Liles. **HT**

DO YOU KNOW A CLINICAL WARRIOR? Submit their story here: https://www.surveygizmo.com/s3/5542956/HealthTrust-Clinical-Warrior-Submissions

Continued from page 8

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- Hackensack Meridian Hackensack University Medical Center

Circle of Excellence – Climate

- Hackensack Meridian Palisades Medical Center

Circle of Excellence – Food

- Hackensack Meridian Raritan Bay Medical Center – Old Bridge

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- Hackensack Meridian Riverview Medical Center
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- Hackensack Meridian Jersey Shore University Medical Center
- Hackensack Meridian Ocean Medical Center
- Hackensack Meridian Riverview Medical Center

Making Medicine Mercury Free

- Hackensack Meridian Bayshore Medical Center
- Hackensack Meridian Jersey Shore University Medical Center
- Hackensack Meridian Ocean Medical Center
- Hackensack Meridian Raritan Bay Medical Center – Old Bridge
- Hackensack Meridian Raritan Bay Medical Center – Perth Amboy
- Hackensack Meridian Southern Ocean Medical Center

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- Putnam Community Medical Center
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- Reston Hospital Center
- South Bay Hospital
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References
1. American Society of Health-System Pharmacists. ASHP guidelines on preventing medication errors in hospitals. AM J Health-Syst Pharm. 2018;75:1493-1517.
2. Institute for Safe Medication Practices (ISMP). ISMP Guidelines for Safe Preparation of Compounded Sterile Preparations; 2016.

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